

DEC 4 1919

Registered at the G.P.O., Sydney, for Transmission by Post as a Newspaper.

Published Weekly.

THE
MEDICAL JOURNAL
OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association

VOL. II.—6TH YEAR—No. 15. SYDNEY: SATURDAY, OCTOBER 11, 1919.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—6TH YEAR.

SYDNEY: SATURDAY, OCTOBER 11, 1919.

No. 15.

COMPOUND FRACTURES OF THE FEMUR IN ITS UPPER THIRD.¹

(With Demonstration of New Pelvic-Femur Splint and of a Splint for Fractures of the Upper Extremity.)

By John Robert Lee, M.D., B.S. (Melb.), F.R.C.S. (Edin.),
Major, Royal Army Medical Corps; Officer in Charge Surgical
Division, Fulham Military Hospital, Hammersmith,
London, W. 6.

At Fulham Military Hospital, London, we have had many opportunities of treating fractured femora and also of seeing the results of treatment in other hospitals as shown by patients who have been transferred to us. The number of patients who come to amputation from sepsis or whose fractured femora join up in bad position with stiff joints, is very great. For instance, during last June we had twenty patients with fractured femora sent over to us from France, where they had been in special hospitals from one to five months; of these some were in fairly good position and not very septic; several of them were more or less

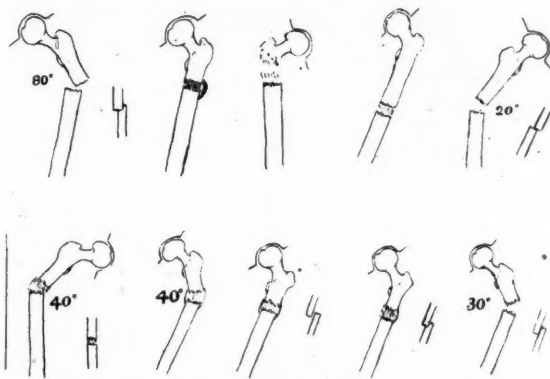


FIGURE I.

Diagrams from ten skiagrams, showing typical displacement.

united in bad position and most of them had sequestra due to trauma and inefficient drainage.

It is of the fractures of the femur in its upper third I wish especially to speak. Ten of the twenty femur cases admitted in June were those of fractures in the upper third. Of these three were in good position and only slightly septic; two were in fairly good position, but septic; five were in bad position and of these three were very septic. Therefore 50% were in bad position and 50% were very septic (see figures I. and VI.). These results should be capable of improvement.

The position or displacement of the fragments in fractures of the upper third as a rule is as follows:—

- (1) The upper fragment is abducted and flexed by the *glutei* and *ilio-psoas* muscles.
- (2) The lower fragment is displaced backwards, upwards and inwards by the hamstrings—quadriceps and adductor muscles. The powerful *adductor mag-*

nus being an exceedingly important factor, there is also some rotation (see figures II., III. and VI.). This deformity is typical, the main causes producing it are:

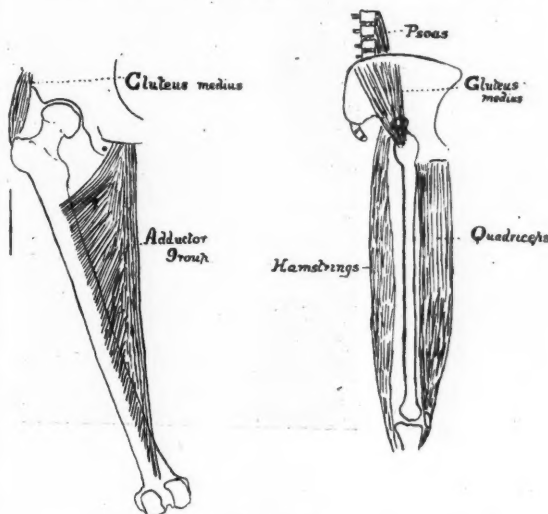
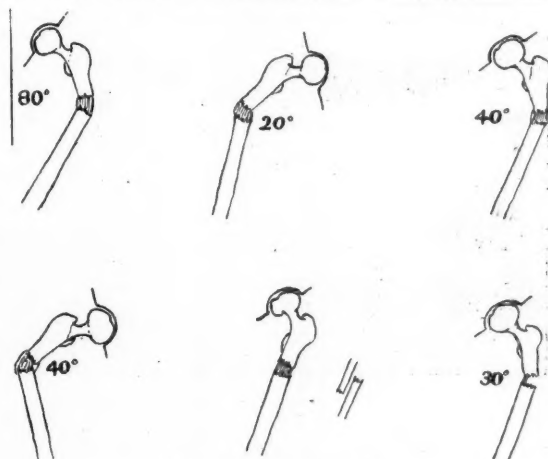


FIGURE II.

Diagrams showing chief muscle groups which cause displacement.

- (1) The direction of the fracturing force.
- (2) The action of the muscle groups.

The essentials of correct treatment rest on an adequate consideration of the anatomical factors and the



After "abduction setting"
of lower fragment.

FIGURE III.

Diagrams from skiagrams, showing abduction of upper fragment.

principles of surgery, the latter including arrest of hæmorrhage, establishment of efficient drainage, provision for antisepsis, general care of the patient, mas-

¹ A communication read at a Meeting of the Surgical Section of the Royal Society of Medicine on December 4, 1918.

sage, etc.. I want, however, to draw special attention to the anatomical factors. The fragments should be brought into correct alignment, the muscle groups placed in a condition of physiological rest and the limb securely fixed in order that there may be no movement of the fragments or spasm of muscles. At the same time any interference with the circulation of the limb should be avoided. Hitherto it has been taught that in fractures of the upper third "the upper fragment, being short, cannot be controlled." Therefore attempts have been made to procure alignment by abducting the lower fragment. This method is wrong in principle. I have taken measurements of a great many men and find that the distance between

the *symphysis pubis* and the adductor tubercle is on an average 5 cm. greater in the abducted position than when the knees are side by side. Hence in the abducted position of the fractured limb the adductor group of muscles have a greatly increased pull, are in a condition of spasm instead of physiological rest and therefore, although the two fragments are brought



FIGURE IV.
Skiagraph showing how after "setting by abduction method" the upper end of the lower fragment is pulled up near the lesser trochanter by adductor muscles.

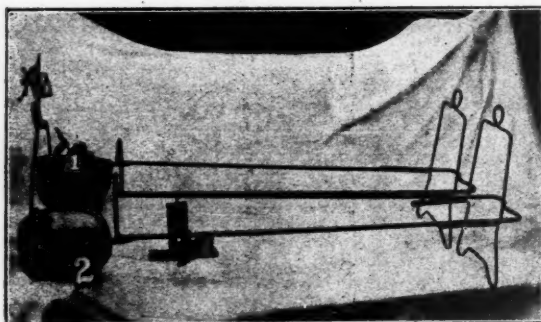


FIGURE V.

The Author's Pelvic-Femur Splint. 1. Pelvis pads on calliper grip. 2. Screws to adjust Thomas's frame. 3. Screws and fly nuts to fix calliper. 4. Piece to bring lower fragment into position.

parallel to one another, an X-ray examination in many cases reveals the fact that the upper end of the lower fragment has now moved upwards a distance of about 5 cm. and takes up a position near the lesser trochanter. The amount of extension that can be applied with safety fails to correct the shortening. Unless the two ends of the bone were impacted, what has

been accomplished is increased overlapping of the fragments and not an elongation of the adductor muscles as shown in figure IV.. It occurred to me that if the upper fragment could be controlled and the abduction overcome, the fragments could be brought into proper alignment with the limb and the muscles in a nearly normal position. With these principles in view, I designed a new appliance which I have called a pelvic-femur splint. It consists of a grip with two pads (figure V.1) which fit the pelvis; modified Thomas's frames for both lower extremities are hinged on to the pelvic grip (figure V.2). The pelvic grip can be adjusted to fit any pelvis comfortably and securely. The pelvis and upper part of the femur on each side are grasped by the pelvic pads. The abducted upper fragment can be controlled and adducted to its normal position quite easily (figure VI.). The



FIGURE VI.

(Dutton.) Compound fracture at junction of middle and upper thirds, showing abduction of upper fragment.

amount of pressure required is regulated and the fragment kept in position by a fly nut working on a screw (figure V.3). Both limbs can be put up in the iron frames in the ordinary way. The upper fragment having been brought into proper position, the lower one can be placed in correct alignment by abducting or adducting, raising or lowering as required while on the splint, the latter working on hinges or joints (near 2, figure V.). Any backward displacement can be corrected by manipulating the small wooden splint by means of screws (figure V.4). Adequate extension can be applied. If much extension is found to be necessary, an adjustable piece similar to that used in the arm splint (figure VII.) can be fitted from the pelvic pad to the axilla on each side; hence the upward thrust of the extending force will be partly

taken by the axillæ and trunk and the pelvic calliper grip not displaced. All these manipulations should be done on an X-ray couch (if necessary under an anæsthetic), so as to see that the two ends of the bone are in actual alignment, not merely supposed to be so. Having completed all manipulations necessary the binding screws are firmly adjusted. The pelvis and lower limbs can be suspended by means of pulleys on a frame, the patient's body raised as needed for convenience of nursing, the prevention of bedsores, etc.. Many patients complain that splints fitted with a ring around the thigh, as in a Thomas's splint, cause much discomfort. With this splint there are no bands encircling the limb, hence no interference with the circulation occurs, which is a very important factor, especially in septic cases.

The splint can be easily applied with a minimum of movement. When it is applied the fragments of the bone are securely held in proper anatomical position, the muscles are

necessary, he is moved as a whole and not in parts. The iron leg portion of the splint can be raised at

right angles to the operating table and thus out of the way should any operative procedure be necessary, the upper fragment being perfectly controlled by the grip pad and the lower steadied by an assistant.

The splint is made double to ensure steadiness and to enable the patient to be moved easily. The final result is that the patient lies with the fractured thigh in its proper position, comfortably beside the healthy



FIGURE VII.
(Dutton.) Fracture of right femur in upper third. After application of author's pelvic-femur splint. Skiagram showing adduction and fixation of upper fragment with good alignment.

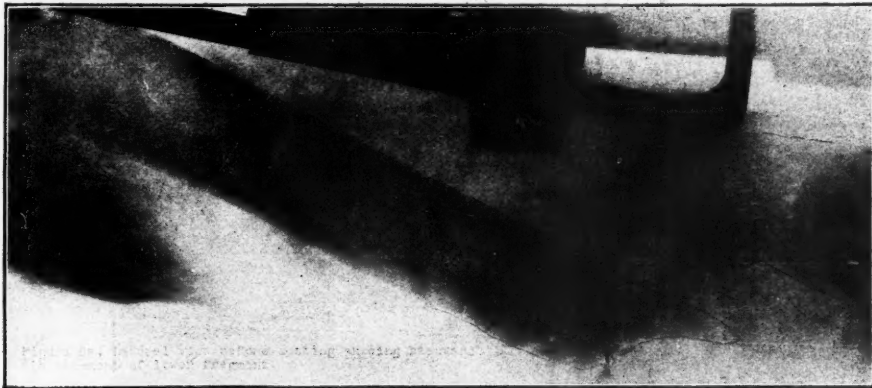


FIGURE VIII.
Lateral view before setting, showing backward displacement of lower fragment.

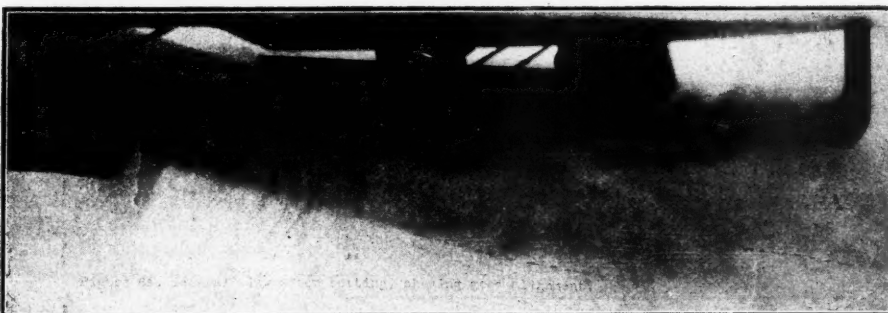


FIGURE IX.
Lateral view after setting, showing good alignment.

limb. In all cases skiagrams are necessary, both antero-posterior and lateral, in order to show whether the fragments are actually in correct position.

While the splint is useful in all fractures below the great trochanter, where there is abduction of the upper fragment, its use is not limited to compound fractures of the femur, but it would be of great value in treating fractured pelvis,

at rest, all necessary dressings, nursing, etc., can be carried out and if any movement of the patient be

intra-capsular fractures and anterior polio-myelitis to give rest to paralysed muscles.

An efficient splint for the upper extremity should be firmly fixed to the patient's body, so as to carry

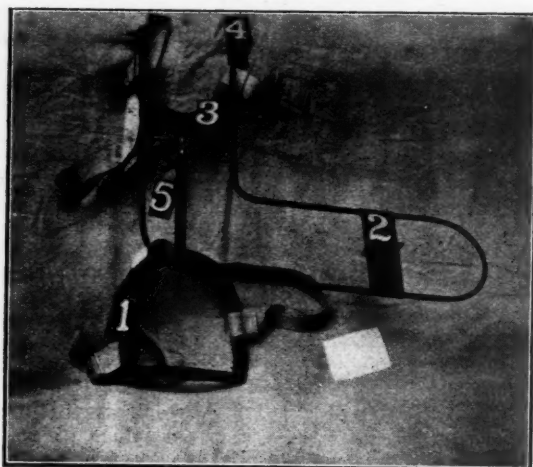


FIGURE VII.

Author's Universal Splint for the Upper Extremity. 1. Padded frame to fit on hip with strap. 2. Adjustable hand piece and splint to carry arm. 3. Axilla pad with strap. 4. Joints to attach arm splint to body part. 5. Set screw to make splint to suit right or left extremity.



FIGURE VIII.

Skiagram of fractured humerus, showing abduction of upper fragment.



FIGURE VIIIa.

Skiagram, after setting with author's universal splint for upper extremity, showing good alignment. The axis of the splint movement passes through the head of the humerus.

the limb, and to keep the fracture in proper position and at rest.

Usually the splint hangs on the limb instead of supporting it. The splint for the upper extremity which has been designed by me consists of two parts (figure VII.). One fits firmly on to the trunk (figure VII.1). The other carries the limb (figure VII.2). The upright trunk part is fitted to the hip with an adjustable piece, which allows its upper forked end to be securely fitted into the axilla (figure VII.3). This part is fastened round the body by two straps. To the upper end of the fork the part which carries the limb is attached by joints (figure VII.4), which allows the arm to be abducted to any desired angle and retained there. The centre of movement passes through the head of the humerus (figure VIIIa.). By releasing a set screw (figure VII.5) on the tubular piece the shoulder portion can be turned round. The limb attachment is then turned completely over, hence the splint can be used for right or left limb equally effectively. The splint can be adjusted so as to support the shoulder in any desired position. The forearm can be placed in either the semi-prone or supine position. Provision is made for any necessary extension. When properly fitted the patient carries his upper extremity with the whole weight supported by

his body, hence the limb is kept quite steady and at rest. Dressing of wounds, massage, etc., can be carried out without interfering with the splint.

After much careful observation of many cases I have designed these two splints, one for each extremity, and have proved that both appliances are efficient, easy to apply and give great comfort to the patient. I have taken this opportunity of demonstrating them, in the hope that their use in treatment of such cases may help to produce better result in the future.

In conclusion, I desire to express my warmest thanks to my colleagues, especially to Lieutenant-Colonel Parsons, for valuable help and encouragement, to Dr. Florence Stoney for her great assistance with the skiagraphic work, to the staff of the Kensington War Hospital Supply

Depôt and to Messrs. Arnold & Sons, who made the splints for me.

THE EARLY DIAGNOSIS OF CANCER OF THE ALIMENTARY CANAL.¹

By L. M. McKillop, M.S., M.B. (Syd.),

Honorary Surgeon to Out-Patients, Hospital for Sick Children, Brisbane.

When you are reminded that the alimentary canal, from both an anatomical and a physiological point of view, extends from the lips to the anus, that it measures some 8 metres in length and is capable of growing some fourteen varieties of new growths, you will, I feel sure, pardon me if I attempt at the short time at my disposal this evening to deal only with the common types and localities of malignant disease in this tract. You will notice from the title of my paper that I intend to deal only with the early diagnosis of cancer. The late diagnosis of the disease is, of course, infinitely easier in the majority of cases, but, after all, is of little practical importance beyond its value for statistical purposes, seeing that, by the time the patient has arrived at this stage of his disease, his chances of cure by operation are correspondingly poorer. To me it has always seemed a matter of much regret that the profession has not endeavoured, as it has done in America, to interest the general public in the matter of the earlier diagnosis of cancer. It falls to the lot of every surgeon, from time to time, to see patients with cancer whom he feels quite positive could have been saved had the disease been properly diagnosed at an earlier phase. It is to the general practitioner that we must look in many cases for an earlier recognition of cancer, particularly when it has originated away from the superficially or from one of the apertures of the body.

Cancer of the alimentary canal is one of the most prolific sources of death in the case of males, and its frequency appears beyond doubt to be increasing; in females it is next in frequency to cancer of the breast and of the uterus. Generally speaking, it is a disease of late middle life and often cuts off a man before the prime of his life has actually been passed. Often, too, it is the more useful members of society who seem to be stricken down by alimentary cancer and the economic loss thereby sustained by the community is of considerable magnitude.

Cancer of the Lip.

This almost invariably takes the form of a true epithelioma. It begins usually towards one corner on the lower lip and is almost confined to males, especially to those who have been in the habit of smoking a short stem pipe. In many cases there is a history of syphilis, even many years back. Seen in its very earliest stage, the condition presented is either that of a crack which bleeds easily and cannot be got to heal or else a small circular or oval breach of continuity at the muco-cutaneous junction. In either case, careful palpation and comparison with the opposite side of the lip will show slight induration. There is no pain, but often there is noticeable salivation. If there be any glandular involvement at this stage, it will be purely inflammatory. The differential diagnosis is to be made from chancre, gumma, lupus and simple traumatic ulcer.

In the case of chancre, the ulcerative condition is relatively later in appearance and the lesion is commoner in women and more likely to involve the centre rather than the sides of the lip. The lymph glands in the neck are found to be involved very early by a painless, shotty induration and the sub-mental gland is affected earlier than the sub-maxillary. The induration of the lip in the immediate neighbourhood of the chancre is much earlier in appearing than in the case of epithelioma. If the floor of the ulcer be lightly scraped and the scrapings transferred to a thin cover glass and stained with Indian ink by the method of Burri, spirochaetes will be seen on examination by dark ground illumination. This, of course, places the diagnosis of chancre beyond all doubt. The importance of an early correct diagnosis in epithelioma of the lip is such that the patient can be definitely promised a permanent cure if a wide excision with complete extirpation of the glands and surrounding fat be done at once. The sub-mental glands should never be left behind, nor should the sub-maxillary glands of the opposite side of the neck be left, as cross-communication is now known to occur in the lymphatics, and recurrence therein may subsequently spoil what looked at the time like a perfect result.

Simple traumatic ulcer of the lip should present no difficulty, as there are the history, absence of induration and the clean appearance of the floor to guide us.

Lupus is occasionally met with in the lip; but here the patient is young and the ulceration is preceded by the appearance of soft, raised, apple-jelly-like nodules.

Gummatous ulcer is occasionally met with in the lips of elderly men. Here the ulceration is usually very rapid, the ulcer itself looks "punched out" and there may be other signs of syphilis present elsewhere in the body. Where doubt still exists, the question may have to be decided by having a complement-deviation test done on a blood sample.

Let us now, so to speak, enter the cavity of the mouth. Herein we meet with three manifestations of malignant disease, of which two, at any rate, are fairly common. These three are: (a) epithelioma of the floor of the mouth, (b) cancer of the tongue and (c) malignant disease of the tonsil, either epitheliomatous or sarcomatous in nature.

Cancer of the Floor of the Mouth.

In its very earliest stage, this terrible disease usually begins as a tiny ulcer, very painful, and situated in the *frænum linguæ*, the *plica sublingualis* or the anterior faucial pillar low down. Salivation is a very early sign, and the patient complains of the irritation caused by salt and condiments in the food. If he is told to protrude the tongue away from the affected side one notices quite a lagging in the movement on that side. This is a most important early sign, not mentioned in any of the text-books, and is one which I have observed in several cases. In the earliest case of cancer of the floor of the mouth which I have yet seen, the patient consulted me because he noticed a sense of "itchiness" on one side of the tongue, just behind the tip. Upon examination I found a varicose condition of the left sub-lingual

¹ Read at a Meeting of the Queensland Branch of the British Medical Association on September 5, 1919.

vein and, on looking for the cause of this, I found upon the floor of the mouth and just below the anterior faucial pillar on the same side a tiny patch of induration. The possibility of syphilis was excluded. He proceeded to Sydney on my advice and saw Sir Alexander MacCormick, who removed the patch, which, upon microscopic examination, proved to be a very early but quite definite epithelioma. The drainage glands in the sub-maxillary triangle were also removed, and I feel sure the condition will not recur.

Tubercle and primary chancre of the floor of the mouth are both very rare. The former condition is exceedingly painful, the latter quite painless. In my opinion, a small, movable, round, distinctly raised tumour, in the centre of which is a small ulcer with even a slightly thickened edge, should be widely and deeply excised, preferably with a cautery knife, and carefully examined. Such a tumour will almost certainly be found to be an early epithelioma. The drainage glands in the neck should always be cleared out carefully as a precautionary measure.

Malignant Disease of the Tonsil.

Here the disease is rarely seen at an early stage, and this, no doubt, coupled with the fact that the lymph drainage from the tonsil is exceedingly free, accounts for the hopelessness of this disease. By the time the patient comes for advice two conditions are practically always present, *viz.*, pain, radiating in paroxysms to the ear of the same side, and stony enlargement of one or more glands of the upper deep cervical group. The patients whom I have seen with this disease have all been heavy drinkers and nearly all of them inveterate smokers. There is practically only one condition with which the early diagnosis may be confused, and that is primary chancre. Here, however, the lymph glands are enlarged very early and pain is absent. Moreover, other signs of syphilis are also usually present. In advanced cases, of course, of tonsillar cancer one has to think of gumma, in which case there is often more than one ulcer. Pain in the ear is absent, except on swallowing, and there is little or no glandular involvement. Where any doubt exists a Wassermann test should be done.

Tubercular ulcer of the tonsil presents the usual appearances of a tubercular ulcer of a mucous membrane and is often multiple. There is no induration, very little glandular enlargement and there are almost invariably signs in the chest of advanced phthisis. In case of doubt a scraping from the floor should be examined for bacilli or a small wedge excised for microscopic examination.

Cancer of the Tongue.

In its very earliest manifestations this disease, which is rarely seen under the age of 40 years and which is almost unknown in females, may take one of three forms apart from the question of its location on the surface of the organ. First of all, it may begin as a small, hard nodule, which might be likened to the appearance of a grain of shot embedded in the mucous membrane. This condition cannot be confused with any other and at once demands radical excision. Unfortunately, it is not the most common type of beginning, but it is the one most often left to "await developments." The second and probably the commonest type of beginning is seen as a tiny breach of surface in the tongue, opposite a jagged

stump of a tooth. To decide whether this breach of continuity in the mucosa is or is not a simple traumatic ulcer, the offending tooth should be drawn. If the ulcer has not of itself healed in about a week or ten days, no further time should be lost, but a wide excision of the ulcer done and the mass microscopically examined. If pronounced malignant, then the whole of the glands in the sub-mental and in both anterior triangles of the neck should be cleared out, as well as all the surrounding fat. Thirdly, cancer of the tongue may begin in a patch of leucoplakia. Syphilis and excessive smoking are probably the two most potent causes of leucoplakia. Any patient who possesses such a patch of leucoplakia should be warned of the possible danger of cancer, so that he can have the patch kept regularly under observation. The first evidence of malignancy in such a case is the beginning of induration, plus a tendency to deepening of the whiteness in the centre of the patch. When the tongue is protruded away from the affected side, it is seen to "lag" as compared with the same movement on the unaffected side. Where any doubt at all exists, the patch should be widely excised and microscopically examined. Most authorities are agreed that in many cases of cancer of the tongue syphilis plays an important rôle in the aetiology. But, none the less, we must beware of regarding an ulcer of the tongue in a person who has had syphilis, as being itself syphilitic. Consequently, unless early and distinct improvement is shown under active anti-syphilitic treatment, no further time should be wasted, but a radical excision performed.

All three forms of cancer of the tongue are histologically similar, *viz.*, they are all squamous-celled carcinomata and the disease is always primary in the tongue itself. Apart from simple dental ulcer, there are two conditions from which early cancer has to be distinguished, *viz.*, gumma and tubercle. In the case of tubercle, the ulcer is extremely painful from the beginning, has little or no induration and has a pale, unhealthy-looking floor. There may be, and usually are, signs of tubercle elsewhere, and if the drainage glands are affected there is not the feeling of bullet-like hardness met with, even in early cancer of the tongue. Furthermore, the ulcer is more liable to occur towards the tip of the tongue than elsewhere, and if the patient is carefully questioned, it will be found that the trouble began with the appearance of a small patch of granulations, which subsequently joined up and then broke down into an ulcer. Gumma begins usually as a small, painless nodule within the substance of the tongue. Intact mucous membrane covers it. The principal complaint of the patient is that his tongue feels lop-sided. Of course, when the gumma approaches the surface, the overlying epithelium becomes very reddened and finally breaks in the centre. Seen at this stage, the nature of the swelling may require determination by the microscopic examination of a small excised wedge of tissue.

Cancer of the Gullet.

This disease, one of the most hopeless manifestations of cancer in the human body, is of importance mainly from the point of view of diagnosis. In many cases an early diagnosis is a matter of some difficulty. Before a definite diagnosis of cancer has been made, the majority of the patients have undergone various

treatments for dyspepsia, gastritis, chronic pharyngitis, cirrhosis of the liver and what not. There are three sites of election for cancer in the gullet, *viz.*, at the pharyngeal and gastric ends of the œsophagus and opposite the site where the left primary bronchus crosses the tube. If the growth is situated at the lower end, the first symptom complained of, as a rule, is persistent heartburn, and to this is soon added the feeling that all the food swallowed has not passed down. If the growth has begun at the upper end of the gullet, *i.e.*, at the lower limit of the pharynx, the patient's first complaint is usually that of an irritating cough, coupled with the feeling that there is something like a fish-bone or other foreign body caught up. No matter where the location of the tumour, the patient very rapidly loses weight. Examination with the head-lamp and mirror may reveal the growth when situated in the pharynx, but when the cancer is situated lower down, recourse must be had to (a) determination of the delay in the propagation of the normal œsophageal bruit, as caused by swallowing a mouthful of water, and (b) the radiographic appearances caused by swallowing a thick emulsion of barium or bismuth. Pain, regurgitation of food and of blood-stained mucus and enlargement of a lymph gland in the left posterior triangle of the neck are late symptoms and need not detain us here. With what other conditions are we likely to confuse early cancer of the gullet? There are five possible pitfalls. (i.) Stenosis caused by the previous swallowing of a caustic. Here the history will guide us. (ii.) Syphilitic stricture. Here we must have recourse to the Wassermann test and the history given by the patient, together with any other manifestations there may be of syphilis. (iii.) Spasm of the gullet. This is to be recognized by the fact that it usually occurs in young women, in whom cancer of the gullet is exceeding rare, that the narrowing is "here to-day and gone to-morrow" if the gullet is screened on several occasions after swallowing bismuth, that it is usually accompanied by vomiting and never by loss of weight. (iv.) Pressure by aneurysm. Here a very careful physical examination, coupled with X-ray examination, will probably suffice to clear up the diagnosis. (v.) Diverticulum of the œsophagus is an uncommon disease, but may prove a thorn in the path to diagnosis. It may be suspected by the history of painless regurgitation of food, but can be absolutely excluded by a screen examination made immediately after swallowing bismuth.

Cancer of the Stomach.

This is probably the commonest manifestation of malignant disease in the male sex. It is relatively uncommon in females and, although usually a disease of the latter two-thirds of life, is occasionally seen in young persons. I have recently had under my care in Brisbane two comparatively young women, each with cancer of the pylorus, confirmed by exploratory laparotomy and microscopic section of a gland removed from the lesser curvature of the stomach. One woman was aged 37 and the other had just reached 34 years. Both have been relieved by posterior gastro-jejunostomy.

In my opinion, there is no other manifestation of

cancer in the human body which may be so atypical in its early symptomatology as cancer of the stomach, particularly of the body of the organ. First of all, there may be no signs or symptoms at all until life is suddenly terminated by an attack of hæmorrhage. In another type of onset the initial symptoms may for some time point the finger of inquiry towards the gall-bladder, or even the appendix. And in yet another type the patient fades away, as it were, with simply a deepening anæmia, emaciation, asthenia and perhaps the occurrence of one or more densely hard, painless lymph glands in the left posterior triangle of the neck. This latter type of invasion is most commonly seen in the elderly inmates of asylums and benevolent homes.

In the more usual type of onset the patient will often give a history of having felt quite well until he ate some unsuitable article of diet, which determined an attack of pain in the epigastrium, with possibly vomiting. Such an onset is often put down as an attack of food poisoning. Soon the patient's friends notice a commencing pallor of the skin. Anorexia is next noticed and is shortly followed by a sense of uneasiness in the epigastrium, terminating in attacks of vomiting, especially at night. In fact, when an elderly man begins to vomit at night for no apparent reason, he is very probably growing a carcinoma in his stomach. It will, of course, be recognized that the closer the growth to the pyloric valve the earlier will both pain and vomiting be experienced. Another sign, already referred to, which may colour the picture very early in the case, is the marked anæmia, so much so that in many cases the patient may be thought for some time to have pernicious anæmia. Loss of weight, as first possibly not progressive, may be an early and important sign. Loss of energy and of a proper feeling of interest in his business may early be noticed by the patient. With regard to the question of the type of pain, this is usually of a burning or boring character and tends to radiate through from the epigastrium to the shoulder blades, is often aggravated by the taking of food, but is rarely of the paroxysmal type seen in gastric ulcer and gall-stones. Constipation is usually a very early and progressive sign and eructations of sour gas from the stomach may also be an early sign.

In yet another group of cases of cancer of the stomach, the disease arises from the degeneration of a pre-existing peptic ulcer, and it is my firm belief that most cases of chronic pyloric ulcer in males will eventually become malignant unless healing can be secured by dieting, or preferably by gastro-jejunostomy. I very much doubt if the former ever occurs in middle-aged men. In these cases it is almost impossible to speak dogmatically about the early symptoms of cancer of the stomach, inasmuch as the malignant process occurs from a quietly progressive, though none the less certain, change. Where doubt exists, and it often does, assistance may be sought from the result of the chemical and microscopical examination of a test meal, as well as from a radiographic examination, but in the majority of cases an exploratory laparotomy is required. This will fulfil the additional object of allowing the surgeon to do a gastro-jejunostomy, with or without primary excision of the ulcer or the pylorus, as the case may be. Cancer of the stomach is

paradoxical in that in some cases it can be diagnosed with the greatest ease and in yet others only with the greatest difficulty. The easiest cancer to diagnose is the one situated at the pylorus; the most difficult, that situated in the wall of the stomach, especially along the lesser curvature, towards the cardiac end. Little or no reliance can be placed upon the radiographic appearances of the stomach in early cancer; one rather should rely upon a carefully-taken history, coupled with an appreciation of the clinical symptoms and the result of the examination of the siphoned-off gastric contents after an Ewald test meal.

Cancer of the Colon.

This is usually a columnar-celled carcinoma. It is most common in the pelvic colon and least common at the hepatic flexure. It is relatively less malignant than cancer anywhere else in the alimentary canal, the lip excepted, and this is owing to the lateness of metastasis; but cancer of the colon may threaten life early, by causing intestinal obstruction. The most common early symptom of cancer of the colon, no matter its site, is progressive constipation, associated with dyspepsia and a feeling of general abdominal discomfort. Pain is relatively a late symptom, as is also the presence of a palpable tumour. But the symptom which most usually brings the patient to the surgeon is an attack of incomplete or complete intestinal obstruction. This, of course, necessitates laparotomy, which reveals the true cause. It is, however, in the early, unobstructed cases that difficulty will arise in the differential diagnosis. Cancer of the pelvic colon in many respects presents the clinical picture of sub-acute appendicitis. In early cases of the former condition, however, there is an absence of rise in temperature and pulse-rate and of an increase in the leucocytes in the blood stream. The guarding of the right rectus is not so noticeable and colic-like pain is experienced well below the navel. Bimanual examination may reveal a mass in the pelvic colon. In females, cancer of the pelvic colon must not be confused with tubal and ovarian swelling. Tuberculosis of the caecum may be confused at an early stage with cancer of the colon, and in some cases the diagnosis may not be cleared up, even after opening the abdomen. As, however, the radical treatment of both conditions is the same, microscopic examination of the removed tissue will settle the question definitely. Radiographic examination after a barium meal and a rectal injection of the same substance should never be neglected in the diagnosis, especially in cases exhibiting mild attacks of obstruction.

Cancer of the Rectum.

The columnar-celled carcinoma is by far the most common type of cancer met with in the rectum. It begins in the epithelium of the mucous glands and may spread right around the lumen of the bowel and cause a stricture at a later stage, but before actual ulceration of the mucosa ensues, with its attendant hæmorrhage. I have known an attack of acute bowel obstruction to be the first evidence to manifest itself of a cancer of the rectum. The disease is equally common in the two sexes, and is usually a disease of middle and late adult life; but fulminating cases are known to have occurred in young children. The disease may reach a well-developed stage without causing

any symptoms whatever; but usually the first complaint is one of increasing difficulty in securing a satisfactory movement of the bowels. In some cases the first complaint made by the patient is that he has "inward" piles, as he has noticed bright blood when at stool. When an elderly man or woman gives a history of having recently developed piles, he or she should be most carefully examined, to exclude cancer of the rectum. I can recall two patients upon whom, some years ago, I operated for hæmorrhoids, who subsequently died of cancer of the rectum, which, unfortunately, I failed to recognize, or, rather, look for, at the time. To resume, as the constipation increases, well marked anæmia develops and, as in the case of cancer of the stomach, may lead to the diagnosis of pernicious anæmia, unless the blood is examined for megaloblasts, etc.. Definite digestive disturbances soon ensue, to be soon followed by the so-called morning diarrhoea. At this stage the patient begins to be troubled with obstinate constipation, alternating with thin, frequent muco-purulent stools. By this time the victim has probably become sufficiently alarmed to consult his medical attendant. Pain is usually a late manifestation of the disease and need not be considered here. Any patient of 40 years or over who gives a history like that just set out, should be subjected to careful digital examination of the rectum, followed by direct examination with an illuminating proctoscope, preferably under an anæsthetic. Nowadays there is little or no excuse for the man who misses a diagnosis of rectal cancer if he is equipped with, and has the sense to use, a good proctoscope.

In conclusion, I fear you will see that I have really only skimmed over the main essential points to be appreciated in the diagnosis of early cancer of the digestive tract, but I seek shelter behind the excuse that the subject is too comprehensive to be dealt with at all justly in the short time at my disposal this evening. If my few remarks in any way help any one of my *confrères* to diagnose even one single case of alimentary cancer at an early stage, then they will have been justified.

Reviews.

THE BLIND.

The first impression of the reviewer in turning the last page of "The Blind," by Harry Best, Ph.D.,¹ is silent wonder at the task which the author has so successfully undertaken. The book contains nearly 800 pages of reading matter, footnotes to nearly every page and at the end of some chapters enormous lists of references. For instance, more than 200 references are given at the end of Chapter IV., dealing with popular conceptions regarding the blind. The book deals solely with the conditions in the United States of America, a person being held blind in whom the sense of sight is so slight as to be of no substantial utility, the proportion being 623 per million of the population. Legal and economic relations to the State are shown in a very complete series of statistical tables, the possibility of prevention unfortunately does not seem to have become materially closer, although the author estimates that nearly two thirds of the blindness is of a preventable character. An extremely interesting conclusion arrived at is that external

¹ The Blind, Their Condition and the Work Being Done for Them in the United States, by Harry Best, Ph.D.; 1919. New York: The Macmillan Company; Melbourne: Macmillan & Co., Ltd.; Crown 8vo., pp. 763. Price, \$4.00.

injury constitutes the most important cause of blindness through the greater part of life, in the first decade most frequently from cutting or piercing instruments, in the second from firearms and after that most often from explosives. So closely has the increase or decrease of blindness been investigated that a table is given, showing injuries to the eye from independence day celebrations, published annually by the *Journal of the American Medical Association*. There has been a steady diminution in the cases of blindness so caused, from 25 in 1905 to 1 in 1915, since when, as a result of efforts to have a "safe and sane Fourth," injuries are so few that they have ceased to be recorded.

The greater part of the book deals with the education and support of blind children and adults, including public and private institutions for their instruction and industrial establishments for their employment, also pensions and indemnities. From the bewildering mass of facts and figures there emerges nothing particularly novel or epoch making, nor is there, generally speaking, any conspicuous difference from, or advance upon, similar work in other parts of the world. As a complete collection of information dealing with the subject and therefore as a book of reference, the work may have its uses, but as an aid to the medical profession, or as a means to attracting the interest of the general public, it defeats its own ends by its very immensity. The author is gifted evidently with great powers of analysis and in exposing his analysis, expresses himself in terms calculated to hold the reader's interest and attention, which makes more real the regret that his pruning knife was not more in evidence. The publishers are the Macmillan Company, of New York, who have lived up to their best traditions in type and binding, but in 1919 the application of the paper knife every pages is not considered an advantage to the average reader.

STATE CHILDREN IN QUEENSLAND.

The Director of the State Children's Department of Queensland has issued his annual report for the year 1918. The Department has now been in existence for over seven years and its activity has become increasingly extensive. During the year under review the only legislative enactment modifying its procedure is the *Infant Life Protection Act Amendment Act, 1918*, which places the responsibility for the administration of the 1905 Act into the hands of the Director of the State Children's Department. Formerly the Act was administered by the Commissioner of Police.

Boarding-Out Institutions.

The policy of the Department embodies the plan of boarding out the children committed to its care in State institutions or institutions controlled by religious bodies. There are sixteen in all.

State Institutions.

In the Diamantina Receiving Depôt at Woolwoowin Protestant children of the southern district are housed until arrangements can be made to board them out with foster mothers. Adjoining the Depôt is a State School, to which a number of these children are sent. The total number of admissions during the year was 360. On the last day of the period there were 22 children in the institution.

At the Infants' Home at Woolwoowin 120 infants received care and medical attention. Of these, 24 died, 42 were dealt with in a manner to be described later and 54 were still in the Home at the end of the year. Many of the inmates are admitted in ill-health. Apparently, no provision is made for the accommodation of the mothers of young infants. It is stated that many applications are received for the admission of infants a few days of age. In these cases the mother is apparently unaware of the great risk attendant on her separation from her baby, or she is callous. The experience of those best able to judge teaches us that infants' hospitals and homes constitute, as a rule, an actual danger to the children admitted. Satisfactory results are only obtainable when the homes are very spacious, when isolation can be carried out effectively and when the staff is large enough to enable the medical officer in charge to place all children suffering from infective processes under the care of special nurses. On the other hand, it must be admitted

that the home conditions of many of these children are so bad that even an overcrowded institution may represent an improvement in the patient's environment.

The Reformatory for Boys at Westbrook is an institution to which boys of all religious creeds are sent. It is stated that, as a rule, boys under 13 years of age are not admitted. It is the only reformatory in Queensland. The number of inmates during the year 1918 was 102 and, of these, 63 were still under care at the end of the year. It was reported that several of the boys were attacked with influenza. In some cases the attack was severe, but in no case was it fatal. There was one death during the year, which was due to an accident. From the account published, it appears that the Superintendent exercises a very beneficent control over his chargees and, by dint of judicious management and humane treatment, he has been successful in inculcating discipline among them. This achievement is particularly to be commended, since it is notorious that the inmates of reformatories are not usually amenable to taming influences. The recourse to boxing gloves as a means of settling differences of opinion is a judicious move and has apparently been the means of reducing petty quarrelling to a minimum. All the boys of school age are required to attend a special school in the institution, while the elder boys were sent to a night school. Unfortunately, this night school had to be closed for a time, owing to the defective lighting arrangements. The defects have been remedied and the night school has been re-opened.

There is a Receiving Depôt at Rockhampton for Protestant children of the central district. At this Depôt an endeavour is made to transfer the children elsewhere as rapidly as possible. Infants are also admitted. During the great flood which visited Rockhampton early in 1918, 14 of the children had to be re-admitted to the Depôt, to place them in safety. It was found that two children at the Flood Relief Home were causing trouble and they, too, were sent to the Depôt. The total number of children dealt with during the year was 79.

The fifth State institution is the Townsville Orphanage at Townsville. It is stated to be the only residential State orphanage in Queensland. During the year 231 children, including infants, were dealt with. There were 114 in the orphanage at the end of the year.

Licensed Institutions.

Of the eleven licensed institutions that are controlled by religious organizations, three are under the care of the Salvation Army, five are controlled by the Roman Catholic Sisters of Mercy, two by the Anglican Church and one by the Methodist Church. The Salvation Army institutions are situated at Yeronga, Toowong and Riverview. The Industrial School for Girls at Yeronga accommodated 32 inmates during the year. The majority of these girls are over the age of 13 and the qualification for admission is briefly enunciated in the word "incorrigible." The Director gives a good account of the year's experience. At Toowong, where only immoral girls are admitted, there were eight inmates; it is stated that the health of these girls was good and their behaviour fair. At Riverview 53 incorrigible boys are handled. From the context, it appears that the word incorrigible must not be taken literally, since it is stated that the conduct of the boys has been very good, that they are attentive to instructions and submit to discipline.

The Roman Catholic Homes include St. Vincent's Orphanage at Nudgee, where there were 573 inmates, and Meteor Park Orphanage, at Neerkoll, where there were 265 children, the Industrial School for Girls at Nudgee, where there were 26 girls, a similar institution at Woolwoowin, where there were 14 girls, and the Magdalen Asylum at Woolwoowin, where there were 49 infants. In the last-named institution, the mothers are admitted with their babies and kept in the Asylum until the children attain the age of two, when the latter are transferred to the St. Vincent's Orphanage.

The two institutions controlled by the Anglican Sisters are an Industrial School for Girls at Clayfield, at which 21 girls were accommodated, and the St. George's Orphanage at Rockhampton, where there were six children. In the last place, it is mentioned that no State children were sent during the year to the Queen Alexandra Home at Coorparoo, which is controlled by the Methodist Church of Australia.

It thus appears that 1,939 children were sent to the fifteen institutions named, including 995 who had been sent there in the previous year. On December 31, 1918, there were 1,064 inmates.

Reason for Control.

The total number of children placed under State control during the year 1918 was 1,955. This figure includes the 944 children admitted and sent to institutions. In the majority of cases the reason for admission was that the mother was a widow and was unable to support her child. Less frequently, the father was alive, but was unable to contribute to the support, owing to some form of invalidity, and in 114 cases the child was illegitimate and the mother was not able to keep her child. In 16 cases a definite order was given on account of neglect, in 75 the children were committed by the Court and in 11 the children were held to be uncontrollable. It is interesting to note that the need for control arising from the enlistment for active service of the father led to the admission of 40 out of the 1,955.

Method of Control.

The State children on the last day of the year under review, were distributed as follows: There were 4,244 boarded with female relatives, there were 937 boarded out with foster mothers, there were 1,064 in institutions and 22 in hospitals; there were 424 hired out, while 278 had been released on probation and 68 had been adopted. It thus appears that, of the 7,000 odd children committed to the care of the State, 60% were left with their parents or relatives, 15% were placed in institutions and 13% were boarded out with foster mothers. It is obvious that the State had the obligation to leave these children with their parents, provided that there is justification to assume that the children will be properly looked after. In cases in which this guarantee cannot be given, or where from other causes the child has to be controlled apart from its relatives, the choice lies between the institutional system and the system of boarding out. The institutional system has very little to recommend it. The control is perhaps less complicated and the machinery for inspection is certainly simpler than that necessary under the other system. The chief defects are that normal children in unfortunate circumstances are frequently associated with mentally defective and vicious children at a time of life when the tendency to imitation is at its height. No figures are given in regard to the proportion of children boarded out with foster mothers singly, in twos, threes and so on. The total number of children in this category was 927 and the number of homes was 257. This means that the average number of children received in the homes of foster parents was 3.72. Unless great care is exercised in the selection of children aggregated in the homes, the practice of allowing a foster mother the charge of more than one child reduces the advantages of the system very considerably.

The children are kept under control until they reach the age of 18. The Act, however, provides for an extension of the control for three additional years, in special cases. Children over the age of 16 may be committed by the Children's Court to the Department for a period of two years. In these instances the age of the children on discharge is necessarily over 18. It is the practice, when the children who are not boarded out, attain the age of 14, they are "hired out." The employment selected in the case of girls is domestic service and in the case of boys farm work. It is stated that full enquiries are made to determine the suitability of the enquirer and the associations of the child in service. No mention is made of any inquiry instituted as to the mental condition of the State child and the possibility of apparent or latent badness constituting a danger to those with whom he or she comes in contact in service. It is stated that the hired out children rendered good service during the year to their employers and that in the majority of cases their "physical ability, self-reliance and robust character" developed satisfactorily. It is further stated that the question of the remuneration of the boys is under consideration by the Board. We are pleased to note that it is recognized that demands other than wages are made in these instances on the employer. The Department collects the wages of the children and, after handing over a small sum not exceeding one shilling per week, invests the balance in the Government Savings Bank.

The amount paid for children placed out in institutions or boarded out varied somewhat in the three primary districts of the State. For children under two years of age boarded out either with their mothers, other relatives or foster mothers, the uniform rate of 10s. per week was paid. Boarded-out children between the ages of two and fourteen years in the southern district cost the State 8s. per week and in the central and northern districts 9s. per week. The payment made for children in institutions varied between 6s. 6d. and 9s. per week.

During the course of the year 77 of the children died. With six exceptions, all these children were under ten years of age and 28 were under one year of age. There were 24 deaths from gastro-enteritis and other intestinal infections and 13 ascribed to indefinite causes, such as marasmus, inanition, congenital debility and convulsions. Nine deaths were ascribed to meningitis. There was one death due to the encephalitis of plumbism.

The number of children discharged from control was 1,035. This figure represents the number of the children who attained the statutory age of 18 or, in the case of children boarded out with relatives, of 14.

The Children's Court.

An endeavour is made by the Department to be represented at the Children's Court at every session. During the year 1918 653 children were dealt with, including 67 brought up on the charge of being neglected. The offences included 367 against the defence laws, 138 of larceny, 16 of using obscene language, 15 of robbing and stealing from the person, 7 of objectionable conduct, 6 of assaulting, 5 of malicious damaging, 3 of rape and so on. There was one charge of drunkenness. Fines were imposed in 46 instances, while 134 children were convicted but not punished. The total number of children committed to the care of the Department was 67.

Infant Life Protection.

On the transference of the powers and duties of the Commissioner of Police under *The Infant Life Protection Act* to the Director of the State Children's Department, it became necessary for the Department to provide machinery for carrying on the work. Two lady inspectors, who had previously been employed in this work, were engaged. The commencement was made on November 1, 1918. At that date there were 177 children in 75 nursing homes. During the remaining two months of the year 41 infants were admitted to the homes and in the same period 58 infants were removed, two by death, leaving a total of 160 in the homes on the last day of December. The birth of every illegitimate child is reported to the Department. In the case of 159 infants, no action was needed, as they were being properly housed and treated. Under the existing law any illegitimate infant may be adopted, provided that the Department is notified of the fact. No approval or sanction need be obtained. The Director regards this arrangement as unsatisfactory. Homes for the reception of infants have to be registered and full inquiries are made as to the fitness of the proprietors, managers and buildings. The death-rate of infants in registered nursing homes is necessarily variable, because some of them are removed to hospitals when they become ill. In 1907 it was 15.9%, while since 1913 it has been between 2.5% and 5%.

University Intelligence.

UNIVERSITY OF SYDNEY.

At a meeting of medical and dental graduates of the University of Sydney held on September 10, 1919, it was resolved to take a ballot of the medical and dental graduates of the University for the purpose of selecting two candidates for election to the Senate to represent the interests of the medical and dental professions. The ballot has resulted in the nomination of Dr. C. Bickerton Blackburn and Dr. G. H. Abbott as candidates. It will be remembered that it was decided at the meeting to select two candidates in addition to Dr. Cecil Purser, who holds a seat on the Senate at present.

The Medical Journal of Australia.

SATURDAY, OCTOBER 11, 1919.

Organised Prophylaxis.

Among the proposals put forward by the Federal Committee of the British Medical Association in Australia concerning the extension of the public health services, there are two recommendations directly aiming at the control of infective disease by the medical profession as a whole. The first involves the establishment of bacteriological and sanitary units in each health district and the second deals with the method of co-operation between the members of the medical profession and the health authorities. Preventive medicine depends primarily on the recognition of the infective processes. For the greater reliability of diagnosis the establishment of bacteriological units in every district is demanded. Before these proposals can be applied with a prospect of success, it will be necessary for the medical profession to elaborate in greater detail a system of organized prophylaxis. The Federal Committee has determined on the main principles. It is on this foundation that a solid structure must now be built. For the practical purpose of preventing disease it may be assumed that the medical profession consists of a large body of general practitioners, of a smaller body of specialists in such branches as children's diseases, tuberculosis, venereal diseases, tropical diseases, diseases peculiar to women, the exanthemata and possibly diseases of the organs of circulation, of a still smaller body of clinical pathologists and finally of the medical officers of the public health departments. If the proposals of the Federal Committee were carried out, there would be a considerable extension of the medical staffs of the health authorities in each State and a reconstitution of their duties. The State Departments would receive assistance in several directions from the Federal Government and consequently it would be necessary to expand the organization of the existing Federal health authority. It will be remembered that one of the essential provisions of the scheme was the introduction of uniformity in the health legislation throughout

the Commonwealth. A start has been made within the last two or three years in this direction in connexion with venereal diseases. Five of the six States have almost identical statutes, aiming at the control of venereal diseases and a bill is to be introduced shortly in the sixth State Parliament for the same purpose. Uniformity of legislative enactments would be followed as a natural corollary by uniformity in the method of administration. Every student of hygiene has experience of excellent acts badly administered, with the inevitable result that the objects of the legislature are either forgotten or but imperfectly attained.

In the elaboration of a detailed scheme, it is necessary to define the obligations of each group of medical practitioners, in order that in the endeavour to gain control over preventable disease, every member of the medical profession may recognize what he has to do. The problem of the general practitioner offers small difficulties. He could perform invaluable service in three distinct directions. In the first place he could collaborate with the medical officer of health or other medical official of the health authority in tracing the "previous case." This presupposes that the diagnosis of an infective process is accurate. In a well-organized system the medical practitioner would produce to the medical officer of health substantial evidence of the existence of a particular infection. The evidence would be supplied in the majority of instances by a competent clinical pathologist. In *praxis aurea* the bacteriological, protozoological or pathological evidence would be obtained from a colleague in private practice. In lodge, hospital or other forms of unremunerative practice, the aid of the departmental or hospital pathologist would be requisitioned. The tracing of the source of infection is often difficult work and hence it becomes essential that there should be harmonious collaboration. In the second place he might be required by the responsible authority to undertake the thorough examination of every individual living in the same house as the patient, or if the infected person were the patient of another practitioner, the examination of any of his patients who might have come into contact with the infected person. Discretion is needed for such a task and if the approach be made with judgement and tact, it would

be possible to ascertain within any given district how many individuals were carriers of infecting organisms and how many were suffering from latent or manifest infections. In the third place the medical practitioner could be used for the purpose of establishing an artificial immunity among the whole community in a given district. If every general practitioner collaborated with the health authority, the inoculation of the entire community within the area of infection could be carried out without any disturbance of the usual relations between the medical practitioner and the families associated with him.

The services of the specialists mentioned below would be of great value in many instances of difficult diagnosis. When a general practitioner felt doubt concerning the diagnosis of a possible infection, the responsible health authority might call upon the specialist to lend his aid. In such a case the department would be held responsible for the fee, if the patient refused to pay it or was unable to do so. The advice and co-operation of the specialist would be of almost paramount importance in the problem of attacking tuberculosis and other wide-spread infective processes. Free use might be made of his particular knowledge. We have already referred to the important work that the private clinical pathologist could carry out in an organized scheme of prophylaxis.

Time is passing and the need for reform is becoming more urgent every day. The expense must be met in the interests of the community. Money spent on a properly-devised plan of fighting disease is money well invested. In the end it leads to large economy. Why not move now?

THE INTERCHANGE OF IDEAS.

Rapid transit has brought in its trail the habit of congresses and conferences. Formerly when men moved laboriously and slowly about the world, the opportunities for discussion were few and even the possibilities of an interchange of ideas by correspondence were limited. To-day men meet frequently to learn what their contemporaries have to say and to bring their own views before other workers in the same field. A few days ago the Council of the New

South Wales Branch held the annual conference with the delegates of the local medical associations of New South Wales. The value of this annual gathering is far greater than the published records reveal. Men practising in the four corners of the State of New South Wales are able to compare notes, to discuss with their colleagues the problems peculiar to their own districts and to widen their outlook by listening to the recounted experiences of those whose sphere of activity differs materially from theirs. To hear a man enunciate his views for the first time is often a revelation, even if these views already appeared in print. The personal element counts for much in life. Owing to the great distances in Australia, it has not yet been possible for the British Medical Association to organize meetings analogous to the Representative Meeting of the parent association at the other side of the world. The difficulties undoubtedly exist, but they are not insuperable. Not long ago there were no arrangements for an interchange of opinions and ideas between the representatives of the six Branches of the British Medical Association in Australia. The establishment of the Federal Committee was the first step toward an ideal federation of the Branches. In the future it may be possible to institute an Inter-State conference of the British Medical Association at which matters of concern to the medical profession within the Commonwealth could be discussed and dealt with. Such a step is desirable in order to foster the Federal spirit and to impel men to relinquish the provincial aspect for an Australian one. A move in the right direction has been made by the introduction of the expedient by many of the Branches of inviting prominent members from a neighbouring State to address the members at Branch meetings. It has been found that more intimate acquaintance with men from other States frequently breaks down a long existing insularity. The experience of the men who served overseas with the Australian Imperial Force has been most valuable in binding men together as Australians. The value of the good work begun in this way will be enhanced by the continuation of the Australasian Medical Congress as congresses of the British Medical Association. Men need to meet each other at short intervals to appreciate the worth of work undertaken elsewhere. The

educational value of an interchange of ideas is not limited to the effect of fresh views being presented. An altered environment, a new set of circumstances influencing the daily life of the worker, a different mental attitude are mental tonics of high potency. It is excellent for us to get the other man's point of view.

ANTIMONY IN THE TREATMENT OF MALARIA.

The majority of medical practitioners who have had considerable experience of the treatment of malaria, have learned to their dismay that, while it is usually possible to cut short an attack of the disease or to anticipate an impending fever and to prevent it, they rarely succeed in curing a patient of malaria altogether. Persons who have become infected in a malarious district, are subject to recurrent attacks of fever long after they have taken up their abode in a non-malarious district. The intravenous application of quinine is apparently capable of killing all the parasites in the blood at the time of the injection, but the parasites that are hidden in the spleen and elsewhere in the body may escape the lethal effect of the drug. In spite of the exhibition of much ingenuity in the endeavour to raise the concentration of the quinine in the blood, in order that the sterilizing action may be thorough and far-reaching, it has been found to be impossible to render the curative effect of quinine permanent in many cases. Time, quinine and the natural forces of the organism acting in conjunction, apparently lead in some cases to an eventual victory over the infection, but we are still ignorant of the mechanism of this action. Captain Adam Patrick has been impressed by the impotence of the practitioner to cure malaria. He was required to take charge of a relatively large number of soldiers transferred from the Salonika army to Malta and decided to make an attempt to cope with the problem of uncured malaria. In January, 1917, Rogers recorded the fact that he had witnessed the disappearance of the crescent forms of the plasmodium in three cases of subtertian malaria after treatment with antimony. Captain Patrick therefore determined to test the efficacy of this treatment.¹ He subjected 104 patients to a planned course of treatment. The men were suffering from tertian or subtertian malaria and all had frequent relapses. During the three months preceding the test treatment, the largest number of relapses in any one patient was 32, while the average was 7. He decided not to divide the group of patients, as their number was not large enough for this purpose. Instead of reserving a group to be treated by quinine alone as controls, he elected to draw comparisons with the records of the preceding three months. The patients were given three intravenous injections of quinine bihydrochloride (one gramme) and five intravenous injections of tartrate of antimony (up to 0.12 gramme). Of the 104 patients treated in this manner, 57 remained free from fever for the period of observation, namely

three months, 12 had one attack during this period and 35 had more than one attack. The relapses varied in severity. In some cases there was merely a rise of temperature to 37.2° C., without a rigor or the appearance of plasmodia in the blood, while in others there was unmistakable evidence of malaria. The freedom from relapse was ascertained to have lasted longer than the three months in many men, who were traced after varying intervals. Less favourable results were obtained in a second series of patients treated in a similar manner in the spring of the year. Notwithstanding this experience, Captain Patrick finds that the treatment is of considerable value. He discusses the divergence between the action of quinine and that of antimony. Quinine kills the parasites in the blood, but fails to reach those hiding elsewhere in the body. Antimony has a gradual effect on the crescent forms and apparently produces a destructive effect, which leads to the prevention of relapses. His account of the treatment will certainly stimulate others to subject antimony to trial. Before the method can be regarded as curative, it will be necessary to have properly controlled groups of patients, in order that accidental or unnoticed agents influencing the patients' condition may be excluded and the value of the antimony may be assessed accurately.

MEDICAL OFFICERS' RELIEF FUND (FEDERAL).

The Trustees acknowledge, with thanks, the receipt of the following donations and promises for the Medical Officers' Relief Fund:—

(FIFTH LIST.)

Queensland.

	£	s.	d.
Dr. J. Lockhart Gibson	100	0	0
Dr. C. E. Williams	60	0	0
Dr. L. M. McKillop	50	0	0
Dr. H. Lee Garde	21	0	0
Dr. J. H. Crawford	20	2	0
Dr. Robert Wallace	20	0	0
Dr. T. I. Wallace	20	0	0
Dr. L. P. Winterbotham	20	0	0
Dr. G. F. Brade	10	10	0

New South Wales.

Dr. E. T. Thring	52	10	0
Dr. W. H. Boazman	50	0	0
Dr. G. H. Walton Smith	50	0	0
Dr. J. C. Halliday	26	5	0
"Nemo"	20	0	0
Dr. W. E. Harris	20	0	0
Dr. R. A. Fox	15	0	0
Dr. J. A. Goldsmid	5	5	0
Dr. G. H. Vernon	5	0	0

Victoria.

Dr. J. Newman Morris	60	0	0
Dr. R. E. Short	50	0	0
Dr. F. R. Legge	50	0	0
Dr. S. Docker Read	10	10	0

Total to October 7, £7,413 9s. 9d.

As a result of a carriage accident, Dr. Richard Henry Denistoun Hope, of Youaumi, Western Australia, died in the Perth Public Hospital on September 19, 1919. Dr. Hope was being driven in a spring cart to a patient's house when a tram-car struck the back of the cart.

¹ *Journal of the Royal Army Medical Corps*, June, 1919.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(125) Papulo-Necrotic Tuberculide.

J. F. Smith records the case of a papulo-necrotic tuberculide of unusual extent (*Brit. Journ. Dermatol. and Syphil.*, April-June, 1919). The patient was a soldier, aged 30, who was supposed to have suffered from impetigo of the scalp in 1916. The lesions recurred. In April, 1918, the skin lesions appeared on the back and forehead, and while improvement occurred from time to time, the affection persisted until he was seen by the author in November, 1918. The eruption on the forehead extended for a short distance into the scalp and on to the temples and eyebrows. On the back it spread as far down as the sacrum. It was limited sharply behind the clavicles. There were one or two lesions and several scars over the sternum. The eruption consisted of papules varying up to the size of 7 mm. in diameter. Some of the papules had broken down, to form an ulcer, which healed under a brownish scab. The papule left a depressed scar after healing. In addition, there were yellowish-pink follicular papules of small size, similar to those seen in *lichen scrofulosorum*. The larger papules were like those of *acne varioliformis*. No signs of tuberculosis were detected. A lesion 24 to 36 hours old was excised and examined. Under the microscope it was seen that there was a cellular infiltration around the capillaries of the corium. The infiltration consisted mainly of plasma cells, with a few mast cells. No giant cells were seen, nor was the cellular architecture suggestive of tuberculosis. The endothelium of the capillaries revealed proliferation. Many areas were invaded with polymorpho-nuclear leucocytes. There was neither dilatation of the capillaries nor thrombosis. The epidermis showed moderate acanthosis and marked oedema. Early stages of intra-epithelial vesicle formation was seen. No tubercle bacilli were seen. The eruption is depicted in two photographs.

(126) Striae Atrophicæ Following Pneumonia.

E. A. Cockayne adds three cases of acute *striae atrophicæ* resulting from an acute infection to the sparse literature of this subject (*Brit. Journ. Dermatol. and Syphil.*, April-June, 1919). In each of his patients the pneumonia had been complicating influenza. The first patient was a young seaman, aged 18 years, who had had a streptococcal empyema. When seen six months after recovery it was noted that four lines of *striae atrophicæ* were present over the ninth and tenth ribs, running parallel to them. The second patient was also a seaman, aged 18 years. He had a large pyo-pneumothorax. Five long lines of *striae atrophicæ* were seen in

the lower lumbar region on each side. The third patient showed the skin changes more or less irregularly arranged parallel to the ribs. He had had a severe attack of influenza, followed by double pneumonia. The patients were not unfat subjects, nor was any oedema present to account for the development of the *striae*. The author suggests that a toxin, either derived from the influenzal infection or from the secondary infections, attacked the elastic fibres of the skin and caused their deterioration or destruction. A mechanical explanation has been put forward in several of the cases previously reported in connexion with the appearance of *striae atrophicæ* accompanying tuberculosis, enteric fever, etc.. The author does not accept a mechanical causation in his cases, but suggests that there existed an inherent weakness of the elastic fibres, a toxin accentuating this weakness and traction on the skin leading to their rupture.

(127) Adiposis Dolorosa.

In the course of a discussion in the Dermatological Section of the Royal Society of Medicine, E. G. Graham Little presented a case which he identified as an instance of Dercum's disease. Many of the speakers expressed doubt as to the correctness of the diagnosis, on the ground of the colouration of the lesions and of the absence of calcareous deposits in the thyroid gland (*Brit. Journ. Dermatol. and Syphil.*, April-June, 1919). The patient was a stout woman, aged 54 years. She had previously been addicted to alcohol. The condition had existed for about seven years. She complained of tumours, which increased slowly. At the time of examination there were two tumours situated above each elbow. They were pad-like masses forming pendulous swellings. Their surface measurements were about 20 cm. by 15 cm.. They appeared to be diffuse lipomata, without any discrete nodules. The skin was of a dark violet redness. The tumours were cold to touch. There were two smaller tumours of similar tissue on the back of each wrist. The tumours were painful and disturbed her sleep. The diagnosis of Dercum's disease (*adiposis dolorosa*) was based on the symmetrical arrangement, the typical diffuse pad-like swellings and the associated pain. The author explained the cyanosis by assuming a diminished vascularity of the fatty new tissue.

(128) Osteo-Myelitis.

F. A. Baetjer (*Americ. Journ. Röntg.*, June, 1919) deals with the radiological aspect of osteo-myelitis. Normal bone structure is first considered. The medullary canal contains the blood supply, lymph vessels, nerves, etc.; in the next place there is the dense cortex and lastly the periosteum. At either end there is the cartilage-covered articular surface. Any or all of these structures may be involved in an inflammatory process. The causative organisms vary, but the process of inflammation is constant, showing only varying degrees of intensity. Four methods of infection

are noted: (1) hæmatogenous or lymphoid, (2) sub-periosteal, (3) extension from joints, (4) direct inoculation, *e.g.*, wounds. In the first group the extension is rapid and quickly involves the bone from within outwards. In the second group the inflammation is generally more limited, owing to the density of the cortex. The third group is characterized by extensive joint infection, with destruction of the articular ends and slow extension into the bones. The infection in the fourth type is admitted directly to the medulla and extends rapidly. Osteo-myelitis gives no distinctive appearances, but in all except the earliest stage, it can be diagnosed by means of X-rays if the fundamental principles of pathological bone changes are considered. The two constant changes noted are bone destruction, followed by bone regeneration. By the extension of inflammation, areas of bone become surrounded and devitalized and sequestrum formation occurs. The appearance of a sequestrum depends directly on the severity of the infection. Malignant disease can usually be recognized, as it commences at a definite point and absorbs the bone as it advances. It never appears as separate areas, with normal bone between, and, further, it destroys the cortex as a whole and never in parts. In osteo-myelitis, near the limits of the infection, new bone is formed, and this tends to surround the infection by a deposition of extensive periosteal bone. At this stage the bone appears to be enlarged and the medullary canal becomes obliterated. This new bone forms the involucrum and eventually surrounds the devitalized bone. From the Röntgenological appearances, the nature and extent of the operation can be determined.

(129) The Treatment of Hodgkin's Disease.

Curtis F. Burman discusses the radiological treatment of Hodgkin's disease and bases his remarks on a series of 100 cases extending over a period of six years. In addition to Hodgkin's disease proper, he includes cases of lymphoma and lymphosarcoma, which are closely allied to it (*Surg., Gynec. and Obstet.*, May, 1919). Exact diagnosis is essential and the methods employed are Röntgenographic examination and blood and tissue examinations. The latter is the most reliable, but X-ray examination is invaluable in estimating the amount of intrathoracic involvement. The author disagrees with Bunting and others, who consider that there is a distinctive blood picture in Hodgkin's disease. Microscopic examination of two different glands is advocated. He holds that the surgeon need have no fear of spreading the disease by this limited interference. It is difficult to distinguish the disease in its early stages from lymphoma, lymphosarcoma, tuberculosis and simple hyperplasia. Medication is useless and arsenic causes a rapid progression of the disease. Radium and Röntgen therapy are pushed to extremes and heavy dosage with filtration is employed. Burman does not give the ex-

act X-ray dosage, but gives 50 grammes-hours as the maximum radium dosage.

BIOLOGICAL CHEMISTRY.

(130) Xerophthalmia Among Rats.

E. C. Buley (*Biochemical Journal*, July, 1919) records observations on the occurrence of xerophthalmia in rats kept under the conditions necessary for conducting metabolic experiments. Osborne and Mendel stated in 1914 that the addition of butter to protein-free milk in the rations of rats fed on purified foodstuffs prevented failure in growth and the development of infectious disease of the eyes. In 1917 McCollum and Simmonds advanced the hypothesis that eye disease might be caused by the absence of the fat-soluble vitamin from the diet. They also recorded the presence of purulent inflammations in the eyes of children who had been fed upon food deficient in fats. In 1918, after further experiment, McCollum, Simmonds and Pitz wrote: "Xerophthalmia and polyneuritis are abundantly demonstrated to have their origin in the lack of a sufficient amount of fat-soluble A and water-soluble B respectively in the diet." Symptoms referable to the eyes appear to be frequent in experiments upon rats. They may be due to a specific dietetic error, or they may be caused by infections encouraged by diminished resistance due to the diet. Recently Harden and Zilwa have assumed eye symptoms to be indicative of the absence of the fat-soluble A from the rations. The authors record the experiments made at Cambridge under the direction of F. Gowland Hopkins. In 1913 Hopkins noted that rats fed upon extracted starch, extracted caseinogen, sugar, salts and lard had developed on ulcerative state of the cornea, with conjunctivitis, within fourteen days from the commencement of the experiments. In the extreme cases there was complete dissolution of the eyeball and rupture of the cornea. Many of the animals died, but a few survived after the addition of 3 c.c.m. milk to their diet. In 1915 these experiments were repeated in the same way, but in a different building. The weights of the rats diminished in the usual manner, but none of the animals exhibited any trouble with the eyes. The author has had during fifteen months the care of 500 young rats fed with varying experimental rations. In every ration there has been present an alcoholic extract of yeast. This extract is free from fat and contains the water-soluble vitamin. Roughly half of the rats have received a supply of the fat-soluble vitamin, the remaining half have received rations in which this vitamin has been deficient or absent. A diet has been considered deficient when the rats failed to grow after the eighth week of the experiment. Many of the rats failed to grow after a few weeks. The rations were considered free from the fat-soluble vitamin when lard was the sole source of the supply of fat. The basal diet was extracted caseinogen, unextracted starch, sugar and salts. The stock ani-

mals from which the experimental rats were selected were fed upon bread, milk, oats and various vegetables. During the whole period only five cases of xerophthalmia occurred among the 500 rats. Two occurred in rats fed on a diet in which the fat-soluble vitamin was supplied. One was observed in a rat fed upon a diet in which the fat-soluble vitamin was absent, one in a rat in which this vitamin was probably deficient in amount and one among the stock rats fed on an ample ration. Of these rats, two were increasing in weight, one had lost weight and one was maintaining a constant weight. One rat had not been weighed. Each of the experimental rats had been under observation for three to four months. There were at least eight other rats under similar conditions and none of these showed any signs of xerophthalmia. The author ascribes her success to the fact that the animals were kept under the cleanest conditions. No trouble was spared to provide a healthy environment. When a rat showed soreness of the eyes, a boracic lotion was liberally employed. The author feels convinced that experimental animals can be kept free from xerophthalmia if the initial infection is prevented. She concludes that xerophthalmia is not a deficiency disease and that it is dangerous to draw conclusions about the absence of the fat-soluble vitamin from a ration from the appearance of xerophthalmia.

(131) Action of Ultra-Violet Rays on Vitamines.

S. S. Zilwa (*Biochemical Journal*, July, 1919) has studied the effects of ultra-violet radiations on the accessory food factors of different kinds. He points out that these bodies can be readily obtained in a highly concentrated form by means of chemical fractionation. The chemical nature of these residues has not yet been determined. The author considers it advisable to study these concentrated residues in the hope that the results may shed light on the chemical constitution of these substances. The anti-scorbutic accessory factor has been employed in the form of lemon juice from which citric acid and other acids have been removed. Autolysed yeast has served as a source for the anti-neuritic element and butter for the fat-soluble vitamin. The ultra-violet radiations have been obtained from a quartz mercury vapour lamp. The material was placed in a quartz tube, which was constantly rotated six inches from the lamp. An exposure of eight hours to the rays was given to each substance. Guinea-pigs were used to study the effects on the treated lemon juice. Three sets of animals were used in the experiment. One group received treated lemon juice, another group treated lemon juice with the acidity adjusted to a definite concentration of hydrogen ions and the third series treated lemon juice of definite acidity but exposed to ultra-violet radiations. Four animals were used in each group, receiving 0.5 c.c.m., 1.5 c.c.m., 2.5 c.c.m. and 5 c.c.m. respectively. All the animals receiving

0.5 c.c.m. succumbed. Two animals receiving 1.5 c.c.m. died, while the third was killed. All the animals receiving large amounts of lemon juice grew without showing any signs of scurvy. Some animals were tested with similar results with treated lemon juice which had been rendered neutral to litmus. The author concludes that the exposure of treated lemon juice to ultra-violet radiations does not influence its anti-scorbutic properties. Pigeons were used in the experiments with autolysed yeast. The birds were kept on polished rice until they developed polyneuritis. A dose of autolysed yeast was given to ascertain whether it had any curative action. The results showed that exposure of autolysed yeast to the radiations did not diminish its curative action on pigeons. A few experiments were done with rats which gave results suggesting that no diminution whatever in the amount of antineuritic vitamin occurs upon exposure of autolysed yeast to the rays. The butter was spread on a plate when exposed to the lamp. It became bleached and developed an unpleasant odour and taste. It was fed to rats along with a basal mixture of starch and caseinogen. It was observed that rats lost weight and died when kept upon the mixture. If the rats were kept on the mixture until their growth had ceased, they grew rapidly on giving them butter which had not been exposed to the rays. The author concludes that the fat-soluble vitamin becomes inactivated when exposed to ultra-violet radiations.

(132) Nomenclature of Blood Pigments.

W. D. Halliburton and O. Rosenheim suggest that the term hemochromagen be deleted from physiological literature (*Biochemical Journal*, July, 1919). They suggest the use of the name reduced hematin for the substance formed by the addition of reducing agents to alkaline solutions of hematin. Hematin should be called oxy-hematin. The adoption of this suggestion would bring these terms into conformity with the terms oxy-hemoglobin and reduced hemoglobin. The name hemochromagen was introduced by Hoppe-Seyler, who ignored the previous work of Stokes and Thudichum. While it would be desirable to use a logical nomenclature expressing the relationship of these pigments, starting with a short name for the iron-free pigment and designating the precursors containing iron, protein and oxygen by suitable prefixes, the failure of the recent attempt to remodel anatomical nomenclature suggests that it is inadvisable to attempt to recast the names of these pigments, which have become firmly established in physiological literature. The term hemochromagen is, however, misleading. Hemochromagen is not a chromogen, but a coloured body. The name is unnecessary, since the use of the prior name, reduced hematin, given by Stokes, expresses the true relationship. The authors suggest the use of 10% sodium hyposulphite as a routine reducing agent. One drop is sufficient and no heat is needed to accelerate reduction.

British Medical Association News.

SCIENTIFIC.

A meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on September 5, 1919, Dr. A. Stewart, the Vice-President, in the chair.

Dr. Ellen Kent Hughes presented several children suffering from congenital syphilis. These children had been treated by intra-muscular injections of arseno-benzol at the Hospital for Sick Children.

Dr. A. V. Meehan exhibited a returned soldier with traumatic myositis ossificans. He also showed a skiagram of the affected muscles.

Dr. Donald Cameron showed three specimens of cancer of the large bowel, exemplifying the difficulty of early diagnosis of carcinoma of the alimentary canal and the necessity for a careful and thorough examination of the patient.

The case histories were as follows:—

CASE 1.—Miss A.B.C., 30 years of age, had been treated by her doctor for eight weeks for constipation and dysmenorrhoea. She was sent to Dr. Cameron on July 18, 1919, for operation for retroversion and hemorrhoids. She stated that she had suffered from constipation for three years. Lately there had been great difficulty in getting the bowels to act. On July 21, 1919, he examined her under an anaesthetic. *Per vaginam* the uterus was found to be in good position. A growth was detected on rectal examination 7.5 cm. from the anus. The growth bled readily when fingered. He had been unable to pass his finger through the strictured portion of the rectum. When manipulated bi-manually the growth was found to be freely movable. On August 4, 1919, an abdominal section in the mid-line was performed. The sigmoid was found to be loaded with faeces. There was a large scirrhus carcinoma involving the rectum. The affected part of the rectum was excised and a large rubber tube was inserted through the anus into the proximal end of the sigmoid flexure and stitched *in situ*. End-to-end anastomosis was carried out. The faecal accumulation was washed away by means of repeated irrigations through a catheter passed through the tube. The patient was quite well when she left the hospital. The specimen showed a carcinoma almost occluding the lumen of the rectum.

CASE 2.—Mr. D.E.F., 62 years of age, was seen for the first time on July 14, 1919. She gave a history of having suffered from mucous colitis for two years. She was a well-developed woman, but stated that she had lost weight to some extent during the last two months. There was no constipation. A lump was felt in the sigmoid. On July 28, 1919, an abdominal section was performed. At the operation 25 cm. of the sigmoid were removed and an end-to-end anastomosis was carried out. On July 30, the bowels acted in response to an aperient. The abdomen was soft and there was no pain. On August 1, 1919, she vomited three times. She became intensely jaundiced. There was no distension of the abdomen. The pulse showed signs of failing. On the following day the failure of the pulse was more marked. The bowels acted several times. The patient was quiet and mentally clear. She gradually passed away. A peculiar odour of the breath was noticed. Death was due to acidosis. The specimen shown was a very large columnar-celled carcinoma of the sigmoid. Notwithstanding its size there had been no symptoms of obstruction.

CASE 3.—G.H.I., aged 61 years, gave a history of attacks of abdominal pain and constipation of several months' duration. There was nothing abnormal to be felt in the abdomen. A bismuth suspension was injected into the rectum. On examination with X-rays, it was found that the fluid had not passed the splenic flexure. On August 28, 1919, the patient was examined under an anaesthetic. No growth was discovered. An abdominal section was performed. A large growth involving the splenic flexure was discovered. This was removed and an end-to-end anastomosis was carried out. The patient did very well. The specimen exhibited was a scirrhus carcinoma, leading to almost complete obstruction of the splenic flexure. A small pen-handle could be pushed through with difficulty.

Dr. Donald Cameron also showed a very large fibroid uterus which he had removed on the previous day. The patient had

had no idea that she had a growth. She had been taken suddenly ill with all the symptoms of an acute abdominal crisis. The diagnosis of a twisted ovarian tumour was made, although the possibility of a perforated appendix was taken into consideration. Dr. Cameron stated that this was the first time he had operated for an acute abdominal crisis and found a fibroid uterus.

Dr. R. Graham Brown exhibited some skiagrams of teeth showing focal infections. In all cases there were apical abscesses.

Dr. J. Lockhart Gibson exhibited specimens of eyes removed for glaucoma.

Dr. Ellen Kent Hughes read a paper on congenital syphilis in children at the Hospital for Sick Children. This paper will be published in a subsequent issue of this *Journal*.

A discussion followed.

Dr. L. M. McKillop read a paper on the early diagnosis of cancer of the alimentary canal (see page 305).

A discussion took place.

MEDICO-POLITICAL.

Annual Meeting of the Delegates of the Affiliated Local Associations of Members with the Council of the New South Wales Branch.

The annual meeting of the affiliated local associations of members with the Council of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on October 3, 1919, Dr. F. P. Sandes, the President, in the chair. Eleven of the local associations were represented.

Welcome to Members.

The President extended a warm welcome to the delegates. He regretted that there was so slender a business paper, but no doubt the fact that many of the members were returning from military service abroad, added to the prevalence of influenza during the earlier months of the year, was responsible. He trusted that the interest of the members throughout the State in matters of professional concern would not diminish and that with the return of more normal conditions the activities of the local associations would be stimulated. He extended a cordial invitation to the members to lunch at the University Club.

Friendly Society Lodge Practice.

Dr. T. W. Lipscomb apologized for the number of motions which stood in his name on the agenda paper. As Secretary of the Medical Politics Committee, the standing committee of the Council to which all matters connected with lodge practice were referred, he was responsible for the task of laying various questions before the meeting. He moved:

That the Common Form of Agreement between medical officer and friendly society lodge, Clause 2, be considered with a view to recommendations being made, if thought desirable, for the amendment of the clause in respect of—

- (a) the fee of two shillings and sixpence;
- (b) the statement in writing signed by the secretary;
- (c) the questions whether or not the fee of two shillings and sixpence is payable where the person to be examined is the wife of a member.

He proposed to take the three points raised in (a), (b) and (c) separately. In regard to the first, it was provided by Clause 2 that the medical officer of the lodge should examine every person seeking to become entitled to any of the benefits of the lodge on payment of the sum of two shillings and sixpence, provided that the applicant submitted a statement in writing from the secretary of the lodge, notifying that the person, if passed by the medical officer, was entitled to the benefits. It had come to the knowledge of the Council that in certain districts this provision was not enforced. He thought that the provision should be maintained and enforced.

Dr. W. C. McClelland (Council) seconded the motion. He agreed with Dr. Lipscomb that there was need for uniformity in the practice in the various districts.

Dr. E. A. R. Bligh (Northern Suburbs Medical Association) asked for the correct interpretation of the clause.

Dr. R. H. Todd (Honorary Secretary) explained that the fee was payable in every case. When the negotiations with

the friendly societies were proceeding, the representatives of the lodges endeavoured to modify the clause in such a manner that the examination fee would be payable only when the applicant was rejected. It was felt that there should be payment for the work and the lodge representatives had assented. He was strongly of opinion that there should be uniformity in practice.

Dr. E. Tudor Jones (Western Suburbs Medical Association) stated that it was the practice in the Western Suburbs Medical Association to charge the examination fee in all cases. No difficulty was experienced in obtaining payment.

Dr. R. A. Robertson (Border Medical Association) said that the fees were paid in all cases in his district. The lodge secretaries collected the fees and paid the money to the medical officer when the latter sent in a statement.

After several delegates had related that fees were invariably charged in their districts, Dr. A. M. Gledden (City Medical Association) pointed out that it was his practice to hand the certificate to the applicant whom he passed for membership, but when he found it necessary to reject a person, he sent the certificate to the lodge secretary.

Dr. R. H. Todd moved as an amendment:—

That the question be referred to the local associations for discussion.

Dr. T. W. Lipscomb seconded the amendment *pro forma*.

Dr. J. Hoets (South Sydney Medical Association) thought that this step was unnecessary. The matter had been considered by the local associations. He held that it would be better to notify the local associations that the rule should be enforced.

The amendment was put to the meeting and failed to obtain the support of the majority. The original motion was then put to the meeting and was carried without opposition.

Dr. T. W. Lipscomb next asked the members to discuss the principle involved under (b). It was a common practice for the lodge secretaries to neglect to send a written statement with the applicant when he presented himself for examination. The medical officer should insist on this provision.

Dr. G. A. Buchanan (Central Southern Medical Association) seconded the motion for the retention and enforcement of the provision. He thought that it was unnecessary to argue in favour of this proposition.

Dr. A. M. Gledden thought that it was advisable to refuse to examine any applicant for membership of a lodge unless he presented a notice from the secretary of the lodge. At times the applicant was known to the lodge officials and was regarded as undesirable. On one occasion he had had difficulty with a lodge because he had examined an applicant of this kind.

In the course of the discussion it was pointed out that the secretaries of the lodges commonly sent a written request to the medical officer to examine a person. Dr. R. H. Todd explained that in regard to applicants for admission to medical benefits of the lodge the clause required the secretaries to send a statement in writing notifying that the applicant was entitled to medical benefits under the terms and conditions of the Common Form of Agreement. It had been held inadvisable to overload the clause. The Branch had introduced a rule supplementing the written statement of the lodge secretary. The medical officer was required to obtain from the applicant his signature to the contract medical benefit certificate. This certificate had been shortened in conformity with the wishes of the delegates expressed at the annual meeting of 1918 and in its present form consisted in a statement that the applicant's total income, together with that of his wife, did not exceed £208 annum and further that he understood that, if at any future time his income, together with that of his wife, exceeded £312 per annum, he would cease to be entitled to the services of the medical officer. The medical officer carried out some duties for the protection of the lodges and the provision contained in Clause 2 was distinctly for this purpose. For his own protection the medical officer insisted on the applicant signing the certificate. He did not think that it would be wise to impose any additional duties on the lodge secretaries than those required by the agreement.

Dr. C. H. E. Lawes (Council) thought that the case would be met if the provision of the clause were carried into effect.

The secretaries should be required to send a notice that the applicant was in fact eligible for medical benefits.

Dr. David Thomas agreed with Dr. Lawes. He considered that it was better to leave it to the medical officer to inquire of the applicant whether his income justified his admission. The doctor could carry out this inquiry with more secrecy than the lodge official.

Dr. R. M. Crookston (Central Western Medical Association) thought that the medical officer should protect himself. In his district applicants were required to sign a simple statement and no difficulty arose.

Dr. E. A. R. Bligh held that difficulty arose when some medical officers in a district carried out the inquiries conscientiously, while others were careless.

Dr. Tudor Jones held that it devolved on the applicant to produce evidence that he was entitled to medical benefit.

The meeting resolved that the provision concerning the written statement of the lodge secretary, as set out in Clause 2 of the Common Form of Agreement, should not be disturbed.

During Dr. T. W. Lipscomb's temporary absence, Dr. R. H. Todd passed on to the consideration of (c). This involved the question whether the fee should be charged when the wife of a member presented herself for examination. In this respect there was a want of uniformity in practice. It should be recognized that the wife of the member who had been passed by the medical officer, became entitled to the medical as well as the other benefits. In some of the districts the lodges had been endeavouring to induce the medical officers to examine wives of members without charging the usual fee. The reading of the clause was quite definite. He interpreted the word person as including the wife of a member. He therefore moved that this interpretation should be accepted.

Dr. E. H. Burkitt (Western Medical Association) objected to the use of the term include. To his mind this would imply that no fee would be required from the wife.

Dr. E. Tudor Jones explained that the Western Suburbs Medical Association the practice was to charge for examination of the wife of a member. It must be remembered that if she were not examined and passed, she would not be entitled to the medical benefit.

At this stage Dr. C. U. Carruthers asked whether they had any power to modify the terms of the Common Form of Agreement. If it was intended to introduce any alterations, would the changes be retrospective?

Dr. R. H. Todd pointed out that the meeting was not competent to alter the Common Form of Agreement. If it transpired that any alterations were desired, the matter would be submitted to a meeting of the whole Branch and the same procedure would be employed as had been followed in the first instance. In no circumstance could an alteration be made retrospective. The subject of discussion was the interpretation of the existing clauses. In order to meet the objection raised to the words used in his original motion, he begged leave to substitute the following:—

That when a wife is examined, the fee of two shillings and sixpence be charged and the wife is not entitled to receive medical attendance until passed by the medical officer.

He thought that this wording would remove all ambiguity. The meeting accepted the substituted motion and carried it without dissent.

In reply to an inquiry by Dr. G. A. Buchanan as to the significance of Clause 26 (d), which reads as follows:—

For the purpose of this agreement the word member shall be deemed to include:—

(d) Widows and children up to the age of 16 years of deceased members, if paying full rates.

Dr. Todd stated that the Common Form of Agreement had been drafted in a spirit of limited benevolence in accordance with the existing practice of the lodges. It had been their custom to deal generously with the widow of a deceased lodge member.

Dr. E. Tudor Jones (Western Suburbs Medical Association) begged leave to withdraw a motion standing in his name on the ground that the matter had been dealt with in the second part of the resolution just passed.

Dr. T. W. Lipscomb moved:—

That it be a recommendation to the Council that a stock of printed copies of "The Contract Medical Benefit

Certificate" be kept and the medical officers of lodges supplied with them in accordance with their requirements. A short discussion followed, in the course of which it was asserted that it might be necessary to modify the conditions of lodge practice in conformity with the altered economic conditions. Dr. A. J. Brady (Council) stated that when the agreement was made it was understood that the rates should not be disturbed for a period of five years. This period had expired. The motion was carried.

Dr. T. W. Lipscomb moved:—

That in ordinary obstetric cases, when it is necessary to administer chloroform or other general anæsthetic, a fee for such administration should be charged.

He said that in some districts a charge was made for the administration, but in the suburbs it was often difficult to persuade the patient to pay it. He held that since a fee would be paid if a second practitioner were called in for this purpose, it should be paid in all cases where an anæsthetic was employed.

Dr. E. H. Burkitt seconded the motion. It had been his practice for many years to charge a fee for an anæsthetic. The lodges had agreed that the charge was reasonable.

The discussion disclosed that the Common Form of Agreement provided both for the attendance on the wives of members in confinement and for the giving of anæsthetics not only in confinement, but also in all other cases when necessary. It was the duty of the medical officer to attend the wife of a member if called upon by the lodge. If the circumstances of the labour demanded the administration of an anæsthetic, or if the woman herself asked for it, the medical officer would be justified in charging the usual fee for anæsthesia. In the majority of cases the patient was quite prepared to pay the fee. Dr. Lipscomb's motion was carried.

The Treatment of Venereal Diseases.

Dr. E. H. Burkitt (Western Medical Association) moved:—

That the Government be asked to supply the various district hospitals with facilities for adequate treatment of venereal diseases, including suitable ablution rooms and modern urological instruments.

The *Venereal Diseases Act*, it was understood, would come into force in January, 1920. If this statute was to be a success, it was essential that proper facilities for treatment should be provided. The country hospitals throughout the State were usually placed a short distance, say a mile and a half, outside the town. This isolation destroyed the privacy that was so essential for the smooth working of the Act. People would want to know why a man was walking to the hospital. He held that it would be necessary to establish a room within the town, which could be used as a general out-patient department. Many persons could not afford to pay adequate fees for work that must prove tedious and difficult. These people should secure treatment in the out-patient departments of the hospitals. The majority of medical practitioners would prefer to treat these persons in such an institution, where facilities could be provided and where the loss of time would be minimized. He anticipated that in each town or, at all events, in each district there would be one practitioner who would be specially qualified to deal with these cases. No doubt other practitioners would take steps to equip themselves later. There should also be a well-trained medical orderly who had learned the duties in the army. The orderly would be invaluable in carrying out the instructions of the medical practitioner responsible for the treatment. For this arrangement it would be necessary to have properly equipped out-patients rooms in the centre of the towns. The reference to the modern urological instruments had been introduced at the request of one practitioner in his district. This practitioner had become versed in their use and was prepared to employ them for the benefit of the patients, if they were provided by the department. He held that it would be wrong of the Government to force an Act on the medical profession, unless they were prepared to guarantee that the country towns and larger centres had means for carrying out the provisions. In the past, many country practitioners had been in the habit of sending patients with chronic or even acute gonorrhoea to the city, as these cases were troublesome to handle. He was convinced that when the Act was in force, the country doctors would regard their duty seriously.

Dr. W. F. Litchfield (Council) seconded the motion.

Dr. S. U. Carruthers thought that it would be a mistake for the Government to do any such thing. He disapproved of the provision by the Government of so-called facilities for the treatment of all sorts of diseases.

Dr. W. F. Litchfield pointed out to Dr. Burkitt that he had left out provision for scientific diagnosis. In the campaign it was essential that the diagnoses should be based on bacteriological findings. The Act required practitioners to give certificates of cure or freedom from disease. These certificates could not be done without the aid of the bacteriologist.

Dr. T. W. Lipscomb replied to Dr. Carruthers that clinics should always be associated with hospitals. They were available to persons of the hospital class and to no others.

Dr. Burkitt agreed to insert before the words "adequate treatment" the words "scientific diagnosis and" in his motion.

Dr. R. H. Todd said that the Health Department was considering what it could do to make the *Venereal Diseases Act* efficacious. The administration of the Act would involve the expenditure of a large sum of money. Considerable sums would have to be spent on equipment. He referred to an inquiry which had been undertaken by Dr. Richard Arthur on the requirements for the purposes of the Act. In a pamphlet that he had compiled and that had been printed at the Government's expense, Dr. Arthur had estimated the probable cost. Dr. Todd thought that the estimate was too low. He understood that the regulations to the measure had been drafted, although they had not yet been tabled. It was believed that they did not differ greatly from those adopted in other States. It was necessary that there should be adequate provision for treatment. Otherwise the Act might prove a failure. The difficulty was that the Government had not enough money for this purpose.

Dr. Andrew Davidson (Council) thought that it might be advisable if a deputation waited on the Government to lay before them the views of the country members.

Dr. L. E. Ellis (Northern District Medical Association) maintained that the venereal diseases problem had to be met. There was the training of the medical profession, as well as the equipment, to be thought of. Provision should be made to enable country practitioners to gain experience in the modern methods of diagnosis and treatment of these diseases. The institution of post-graduate courses would be highly beneficial.

The motion was put to the meeting and carried.

Life Insurance Examination.

At the request of the Federal Committee the question of the advisability of adopting a uniform minimum fee of one guinea for the examination of a proponent for life insurance and report was reconsidered. The various aspects of the question were discussed and the history of the admission of a fee of 10s. 6d. for examination without analysis of the urine and report on the short form was recounted. This matter has already received the attention of the delegates at previous meetings. After full debate it was determined not to alter the previous decision.

Votes of Thanks.

The President, Dr. F. P. Sandes, thanked the delegates for their attendance, which, in several instances, was attended by the considerable inconvenience and involved a long journey. He spoke of the value of the discussions and congratulated them on the manner in which they had dealt with the business.

On the motion of Dr. E. A. R. Bligh, the delegates passed a hearty vote of thanks to the President for the admirable way in which he had conducted the meeting.

The following gentlemen have been nominated for membership of the New South Wales Branch:—

Eric Payten Dark, Esq., M.B., Mast. Surg., 1914 (Univ. Sydney), Bungendore, New South Wales.

Charles Badham, Esq., M.B., 1917 (Univ. Sydney), Clifton Gardens Hotel, Mosman.

PNEUMONIC INFLUENZA.

According to a notice published in the *Queensland Government Gazette*, No. 150, of October 4, 1919, influenza is de-

clared to be an infectious disease within the meaning of the *Health Acts, 1900-1917*, in the areas of the shires of Etheridge and Rosalie and the townships of Killarney, Tannymore and Mount Colliery. A special order has been issued on October 1, 1919, imposing the usual influenza restrictions on persons within the shire of Etheridge.

Naval and Military.

APPOINTMENTS.

The following announcements have appeared in the *Commonwealth of Australia Gazette*, No. 111, dated September 25, 1919:—

Permanent Naval Forces of the Commonwealth (Sea-going Forces).

To be Surgeon Lieutenants—

Temporary Surgeon Lieutenant Carlton Atkinson Ellis, F.R.C.S., R.N., permanent service. Date of appointment, 22nd March, 1919; seniority in rank, 4th August, 1914.

Temporary Surgeon Lieutenant Ernest Sydney George Killen Vance, M.B., R.N., permanent service. Date of appointment, 30th March, 1919; seniority in rank, 10th May, 1918.

PROMOTION.

To be Surgeon Commander—

Surgeon Lieutenant-Commander (Acting Surgeon Commander) Alexander Ruan Caw. Dated 1st August, 1917.

TERMINATION OF APPOINTMENT.

The temporary appointment of Surgeon Lieutenant Arthur Neville St. George Burditt, M.B., B.Sc., M.S., is terminated on 1st October, 1919, at his own request.

Australian Imperial Force.

APPOINTMENTS TERMINATED.

Second Military District.

Major H. S. McLelland. Dated 19th August, 1919.

Captain G. A. Lawrance, M.C.. Dated 2nd September, 1919.

Third Military District.

Colonel H. C. Maudsley, C.M.G., C.B.E.. Dated 15th July, 1919.

Captain A. V. R. Hansen. Dated 3rd July, 1919.

Captain A. J. McK. Fargie. Dated 12th July, 1919.

Fourth Military District.

Lieutenant-Colonel H. S. Newland, D.S.O.. Dated 7th September, 1919.

Captain E. B. Thomas. Dated 21st September, 1919.

Captain W. A. James. Dated 20th August, 1919.

Sixth Military District.

Captain S. G. Gibson, M.C.. Dated 13th September, 1919.

Australian Military Forces.

GRANT OF HONORARY RANK.

The undermentioned, who have served in the Australian Imperial Force as commissioned officers, having been appointed to the Reserve of Officers (temporarily) and being granted honorary rank equivalent to that held by them in the Australian Imperial Force:—

Officers who, on appointment for active service outside Australia, were not serving in the Australian Military Forces:—

First Military District.

To be Honorary Major—

T. C. C. Evans, D.S.O.. Dated 29th January, 1917.

To be Honorary Captain—

A. T. H. Nisbet. Dated 1st March, 1916.

Second Military District.

To be Honorary Majors—

A. J. Mollison. Dated 20th June, 1917.

R. M. McMaster, D.S.O.. Dated 24th August, 1917.

E. W. Ferguson. Dated 12th October, 1917.

To be Honorary Captains—

C. O. Hellstrom. Dated 15th May, 1916.

A. S. Cockburn. Dated 25th July, 1916.

W. D. Quilty, M.C. Dated 1st August, 1916.

G. M. Whish. Dated 17th October, 1916.

R. Roger. Dated 16th August, 1918.

Third Military District.

To be Honorary Lieutenant-Colonel—

E. W. Gutteridge. Dated 11th November, 1918.

To be Honorary Majors—

A. J. Brennan. Dated 27th April, 1917.

A. M. Davidson. Dated 28th January, 1918.

T. F. Brown, D.S.O.. Dated 29th January, 1917.

To be Honorary Captains—

A. V. R. Hansen. Dated 15th June, 1916.

G. Sutton. Dated 1st August, 1916.

F. G. T. C. de Crespigny. Dated 11th May, 1917.

N. J. Mackay, M.C.. Dated 22nd March, 1916.

Fourth Military District.

To be Honorary Lieutenant-Colonel—

L. O. Betts, O.B.E.. Dated 20th November, 1918.

Officers who, on appointment for active service outside Australia, were serving, and are now serving in the Australian Military Forces:—

Second Military District.

To be Honorary Lieutenant-Colonels—

Captain and Brevet Major J. R. M. Beith, Australian Army Medical Corps. Dated 11th November, 1918.

Captain F. C. Wooster, Australian Army Medical Corps. Dated 11th November, 1918.

To be Honorary Majors—

Captain S. V. Appleyard, D.S.O., Australian Army Medical Corps. Dated 20th June, 1917.

Captain R. B. North, Australian Army Medical Corps. Dated 20th June, 1917.

Honorary Captain A. S. Curtin, Australian Army Medical Corps Reserve. Dated 24th August, 1917.

Honorary Captain E. P. Barbour, Australian Army Medical Corps Reserve. Dated 1st July, 1918.

Honorary Captain A. E. Machin, Australian Army Medical Corps Reserve. Dated 1st July, 1918.

Honorary Captain C. M. O'Halloran, Australian Army Medical Corps Reserve. Dated 1st July, 1918.

Third Military District.

To be Honorary Lieutenant-Colonel—

Captain B. M. Sutherland, O.B.E., Australian Army Medical Corps. Dated 19th September, 1917.

To be Honorary Major—

Honorary Captain R. G. McPhee, Australian Army Medical Corps Reserve. Dated 11th November, 1918.

Fourth Military District.

To be Honorary Lieutenant-Colonels—

Captain W. D. K. MacGillivray, Australian Army Medical Corps. Dated 1st July, 1918.

Captain C. Yeatman, O.B.E., Australian Army Medical Corps. Dated 19th September, 1917.

The undermentioned, who have served in the Australian Naval and Military Expeditionary Force as commissioned officers, to have the rank held by them in the Australian Naval and Military Expeditionary Force confirmed as honorary rank in the Australian Military Forces:—

Officer who, on appointment for active service outside Australia, was serving, and is now serving, in the Australian Military Forces:—

Second Military District.

To be Honorary Major—

Honorary Captain L. H. Hughes, Australian Army Medical Corps Reserve. Dated 26th September, 1918.

Officers who, on appointment for active service outside Australia, were not serving in the Australian Military Forces:—

Second Military District.

To be Honorary Lieutenant-Colonel—
R. Fitzherbert. Dated 1st January, 1918.

To be Honorary Major—
C. W. Bray. Dated 1st January, 1918.

THE REGISTRATION OF OPTICIANS.

In view of the proposal to introduce into the Victorian Parliament a bill to provide for the registration of opticians as sight-testers, a deputation from the Ophthalmological Society of Victoria waited on the Chief Secretary on September 10, 1919, for the purpose of bringing to his notice the views of the medical profession on this important subject. Dr. J. A. O'Brien, Government Medical Officer, introduced the deputation. He stated that the Ophthalmological Society was under the impression that the proposed legislation would provide for the registration of persons who were not competent as eye-testers. If the sanction were given some of those registered would use it for the purposes of advertisement. At the present time, before any one could call himself an oculist in Victoria, he would have to be a registered medical practitioner.

Dr. E. L. Gault said that this was not the first time they had approached the Government on the subject. On previous occasions they had been able to represent their case in such a way that the Government had dropped the proposed bills. The optician had brought forward their bill with perseverance. The deputation understood that the opticians put forward the argument that the proposed measure was in the public interest. He, the speaker, would offer impartial advice in the matter in the public interest. He did not think that the views of the opticians would be accepted until the opinions of those who were regarded as the custodians of the public health, had been obtained. Opticians complained of charlatans going about the country selling spectacles and damaging the eye-sight of the people. The public undoubtedly suffered in this way, but they also suffered from the operations of opticians, both skilled and unskilled, in the towns. The remedy was not to be obtained from opticians unless they were required to undergo a full medical course. The only person who should be licensed to treat the eye, was a qualified medical practitioner. The public should be taught that they ran the same risk when they consulted an optician in regard to defective sight as when they consulted a pharmacist instead of a doctor in regard to a bodily disease. The proposed legislation would do harm and occasion misrepresentation; it would license ignorance and quackery. Hitherto the Government had followed a policy of non-interference with these persons. This was, as far as he was aware, the first time any untrained practitioners had asked to be registered in Victoria. It would produce a public opinion that opticians were proper persons to consult about the eyes. The public would think that they were saving money and taking no risks. He hoped that Parliament would refuse to sanction any legislation which would have the effect of so misleading the public. He and his colleagues had great respect for opticians as skilled, trained workmen. They could supply accurate spectacles. He was content to allow the law of competition to determine what profits they might make as tradesmen. In some cases it was 400%. But when they aspired to the status of professional men, they should be compelled to go through a complete course of medical study. If the bill became law the opticians would call themselves sight-testing opticians; they would advertise their ability to treat a great number of diseases. They would sit in their optical parlours, diagnosing cataracts when none existed, and ordering spectacles when there was no necessity for them. He felt a great aversion to that class of man. The Government should consider whether it would be wise to create men of that type and to give them the hall mark of capacity, for which they were quite unfitted. It would intensify the damage already done to the public by opticians; it would mislead the public by guaranteeing men who were ignorant of medical science and practice.

Dr. A. L. Kenny prefaced his remarks by stating that as practising oculists of the city they had no personal interests in their appeal. Irregular practices were the best

sources of increase to *bona fide* medical practice. They were present solely in the public interest. They did not regard the optician as a man qualified to test sight. In the bill brought in by the late Mr. Murray and Mr. Thomson "sight testing" was defined as the practice of measuring the powers of vision by the employment of methods other than the use of drugs and the adaptation of lenses for aiding defective sight. It was recognized by oculists all the world over that it was necessary to use drugs in diagnosing errors of refraction. By leaving out the use of drugs, the optician made himself unfitted to do the work of sight testing properly. The optician had no training in the use of drugs nor a knowledge of the drugs. Nor had he any training in physiology. The eye was part of the human body and must depend on the condition of that body. The optician did not seek training and was therefore incompetent to test sight. No Government should give him a mark or sign or certificate implying that he was qualified. He was not competent to detect a disease of the eye. He was competent to make up the prescriptions given by a medical man trained in the treatment of eye diseases. He, like the pharmacist, was an auxiliary to the trained practitioner. Dr. Kenny thought that they had demonstrated to the Chief Secretary that these people were incompetent to do the work. The matter should not get as far as Parliament. It was stated that sight testing was simply a matter of elementary optics. There were cases in which an error of refraction could be corrected, but in which it would be most unwise to give the patients spectacles. In such a case there might be a disease of the kidneys. If the sufferer went to the optician and he gave him glasses, it would do harm. It might be the worst thing in the world to encourage the person to use the eyes. At the present time the poor were admitted at all hospitals and they could obtain an examination of the eyes without cost. Arrangements existed for the supply of spectacles at reduced rates. Dr. Kenny said that there was no question that damage was done by the men travelling round the country, but far greater damage would be done by giving to opticians, no matter how highly trained technically, a certificate that they were competent to treat errors of refraction or diseases of the eye.

Dr. H. Riddell Stanley, the President of the Ophthalmological Society, stated that opticians had done more harm than good. He had been called upon to treat patients who had almost lost their sight through having been treated by opticians. With more encouragement, more harm would be done by them. The Chief Secretary asked whether these patients had come from reputable opticians. Dr. Stanley replied that that was so. He had had three or four cases of this kind during the past five years. He presumed that other oculists had had the same experience.

Dr. W. Kent Hughes said that opticians could test the sight of elderly people and order glasses, but when the eye was diseased, they could not detect it. They ordered glasses and did harm by allowing the eyes to be used.

Dr. Kenny agreed and, in reply to a question by the Chief Secretary, stated that, while an oculist might make an error, the optician could not avoid an error, such as the failure to recognize glaucoma. In reply to the objection that the bill would not give the optician power to treat diseases of the eye, Dr. Kenny retorted that it would give him power to test sight and make glasses. A man with disease might have defective sight. If he went to the optician registered by the Government, it would often mean the end of his sight. The Chief Secretary asked whether they thought the bill went too far in the public interest. Dr. Kenny assented. They did not ask the Government to stop opticians treating patients, if the patients liked to take the risk, instead of going to a doctor. They had not asked that pharmacists should be prevented from treating people. Opticians were skilled tradesmen, but not trained medical practitioners. Even if the technical training were increased, he would not become competent to test sight.

The Chief Secretary suggested that the special board would enable the Government to look after opticians. They could not be touched at present. Dr. Kent Hughes thought that the control could be exercised over them as opticians, but not as sight-testers, as the practice would be legal, even if the mistakes did harm. The Chief Secretary thought that opticians claimed that they could detect disease. They would

send these patients to oculists. Dr. Kenny pointed out that this was not so. They could not recognize all diseases without a full medical training. Dr. Kent Hughes claimed that it was one of the most advanced studies in medicine and the optician would need a surgical and medical course to enable him to detect all cases of disease. They did not object to the registration of opticians; they merely objected to their registration as sight-testers. The Chief Secretary said that the public obtained a certain amount of satisfaction from opticians. If they cut out sight testing, they would ruin the opticians' business. Dr. Kenny replied that they did not propose to stop the business, but they did not want the Government to certify that these men were competent to test sight. They could continue if the public knew that they were taking a risk. In reply to a question, he said that they would be satisfied if the clause dealing with sight testing were removed.

The Chief Secretary said that he had asked several questions because he wished to get down to the bedrock of their objections and to alter the bill to bring it into conformity with their beliefs. He wanted to give the public some protection and he had told the opticians that he would like to hear the views of the medical profession. The question had not yet been before the Government. He would place their representations before the Cabinet when it was under consideration.

The deputation thanked the Minister and withdrew.

Obituary.

ARTHUR EBENEZER BARRINGTON.

By the death of Dr. A. E. Barrington the district of Benalla, Victoria, has suffered the loss of a sound professional man and active citizen.

Arthur Ebenezer Barrington was born in Cork in the year 1862. He came to Australia shortly after the completion of his medical course at the Dublin University in 1888, and for a period of eighteen months acted as *locum tenens* for a fellow-practitioner in Castlemaine, Victoria. In the year 1890 he purchased a practice at Benalla, in which centre he followed his profession until ill-health compelled him to relinquish active work, a few months prior to his decease.

He was of a retiring disposition, cultured and musical. He was an enthusiastic student of Esperanto, and for some time conducted a class for Esperanto in Benalla. He gave freely of his time and energy to his fellow-citizens and held various important offices. For many years he was Returning Officer for the Benalla State Electorate and he also served as a Commissioner of the Water Trust for a long period. He held the position of Health Officer until his retirement from practice.

Arthur Ebenezer Barrington was prominently identified with the Benalla Bowling Club, of which he was one of the originators and an early President. For many years he was associated with the Benalla Racing Club, being an active member of the committee. Ill-health, however, obliged him to resign his various offices and to abandon his professional work. For the four months immediately preceding his death he lived privately.

His illness was long and harassing, but was borne throughout with great fortitude. His widow, without family, survives him.

Correspondence.

SUPERACUTE PULMONARY OEDEMA.

Sir,—Dr. Southwood's excellent description in *The Medical Journal of Australia* of October 4, 1919, of an example of superacute pulmonary oedema in a man suffering from chronic Bright's disease makes interesting reading. The subject of acute pulmonary oedema is well worth attention and no wise man will attempt a "cock-sure" explanation of it. I incline to the view that an important factor is a relative failure of the left heart, while the right is still acting strongly. In an article in *The Medical Journal of Australia* of January 5, 1918, entitled "The Appearances of

the Lungs After Death from Asphyxia and the Reasons Therefor," I pointed out that sometimes the lungs were light and dry and sometimes engorged and oedematous after death from asphyxia and suggested as an explanation that in the former cases the right side of the heart failed first and in the latter cases the left side was the first to give out. I ventured the further opinion that in cases where the dyspnoea was chiefly inspiratory, as in fibrinous bronchitis and blood sucked freely into the thorax from the large veins, the right heart fails first and that in cases where expiration is stimulated, as in cases of drowning, the left side fails first, because then the right side is not so subject to paralytic distension. In Dr. Southwood's case we have an enlarged left ventricle struggling to overcome an excessive peripheral resistance and that it might suddenly weaken, while the right ventricle is still acting well, is not improbable. Whether there is another factor, such as a failure of the peripheral circulation, cannot be dismissed lightly. It follows if the capillary portion of the circulation were to suddenly lose its tone, the capillary bed would become a marsh, the circulation fail and the tissues become oedematous. But why should such a disaster limit itself, as it does in the cases under discussion, to the lungs? However that may be, I have formed the tentative opinion that the extraordinary and characteristic blue congestion of the lungs that one sees frequently after death from pneumonic influenza is largely due to a failure of the peripheral circulation following on a loss of tone of the smaller blood vessels and capillaries which occurs everywhere, but which for some reason produces its greatest effects in the lungs.

Yours, etc.,

W. F. LITCHFIELD.

207 Macquarie Street, Sydney,
October 5, 1919.

THE MIND FACTOR IN DISEASE.

Sir,—In your excellent article on the above subject you close by saying: "Suggestion can do much, but it cannot replace these or analogous methods of treatment." As one who devotes most of his time to the practice of psycho-therapy, perhaps you will allow me to say that what the average medical man wants to be fully seized of is, what suggestion can do. There is still a great deal of prejudice and ignorance in the ranks of the profession about the whole subject of suggestive treatment. Its application, whether by hypnotic suggestion, suggestion alone, persuasion, psycho-analysis, etc., is still either damned by faint praise, or openly scoffed at by men you would expect to know better. In 1884, when passing through arts in Aberdeen, Professor Stirling, then Professor of Physiology (now of Owen's College, Manchester), lectured to us on hypnotism. He prophesied the coming of a day when we should understand it better and make greater use of it. I trace to the "suggestion" of that lecture my life-long interest in psycho-therapy, whether as shown at Lourdes, holy wells, shrines, in the Emmanuel movement, the hosts of Christian scientists or its tardy and grudging use in medicine. Some sixteen years ago I entered medicine at Sydney University. In passing through its various classes, I heard a reference made to hypnotism once, to "suggestion" never.

As in the medical school, so, too, in the hospital, I never heard the slightest allusion made to psycho-therapy by any of the teachers in clinical medicine. I may be wrong, but for the past ten years I do not remember one single evening being devoted to this subject by the B.M.A.. All honour to Sir Thomas Anderson Stuart; he tried two years or so ago to introduce something in the shape of a psycho-therapeutic clinic to Prince Alfred Hospital, but, so far, I do not know that much has come of it. Can one wonder, then, that men, turned out utterly ignorant of the very rudiments of psychology, with an unbounded faith in a pill or a potion, with an itching desire to use a scalpel, should have no time for "mental medicine" and no use for a "psychical" scalpel that might "pluck from the memory a rooted sorrow"? If Dr. Springthorpe in his article on "War Neuroses and Civil Practice" (*The Medical Journal of Australia*, October 4, 1919) has stressed the value of psycho-therapy, surely it is not before time. Medicine is only now beginning to take the question up. We do not know yet what suggestion can do,

nor what it cannot. It has never had a fair trial. It is rash to say it has no influence over organic lesions. Professor Hewlett, of London, in his "Pathology" has had to alter the old definition of inflammation. He says: "In persons susceptible to hypnotic suggestion that a burn which has been caused in the skin will lead to hyperæmia, redness, exudation and swelling at the spot, i.e., the changes of acute inflammation"; but let that pass. I am convinced that what we need is a greater and greater knowledge of what suggestion can do, and a place for a study of the new psychology in the medical curriculum; then psycho-therapy will find its proper sphere in medicine and become the chief corner-stone in the newer therapeutics, without in any way encroaching on the domain of the surgeon, the bacteriologist or any other specialist in medicine.

Yours, etc.,

DONALD FRASER.

30 College Street, Hyde Park, Sydney,
October 6, 1919.

Medical Appointments.

Dr. Leslie Fetherston (B.M.A.) has been appointed Government Medical Officer at Scarborough, New South Wales.

Dr. Winifred Lurline Dillon has been appointed on probation for six months Medical Officer in the Medical Branch of the Department of Public Instruction of New South Wales.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xix.

University of Sydney: Professor of Medicine.

The University of Melbourne: Lecturer in Pathology.

Department of Public Health, Queensland: Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other Contract Practice. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital.
TASMANIA. (Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.

Branch.	APPOINTMENTS.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.)	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmaln United Friendly Societies' Dispensary. Canterbury United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Friendly Society Lodges at Lithgow. Friendly Society Lodges at Parramatta, Auburn and Lidcombe. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society..
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

- Oct. 14.—N.S.W. Branch, B.M.A., Ethics Committee.
Oct. 15.—W. Aust. Branch, B.M.A., Branch and Council.
Oct. 16.—Vic. Branch, B.M.A., Council.
Oct. 17.—Eastern Suburbs Med. Assoc. (N.S.W.).
Oct. 18.—Northern Suburbs Med. Assoc. (N.S.W.).
Oct. 21.—Tas. Branch, B.M.A., Branch and Council.
Oct. 21.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Oct. 24.—Q. Branch, B.M.A., Council.
Oct. 28.—N.S.W. Branch, B.M.A.; Medical Politics Committee; Organization and Science Committee.
Oct. 29.—Vic. Branch, B.M.A., Council.
Oct. 30.—S. Aust. Branch, B.M.A..
Oct. 31.—N.S.W. Branch, B.M.A..
Nov. 3 to 12—Vic. Branch, B.M.A.; nominations received for Council.
Nov. 4.—Tas. Branch, B.M.A., Branch and Council.
Nov. 7.—Q. Branch, B.M.A..
Nov. 11.—N.S.W. Branch, B.M.A., Ethics Committee.
Nov. 12.—Vic. Branch, B.M.A..
Nov. 12.—North Eastern Med. Assoc. (N.S.W.).

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated. All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney.